61ST ANNUAL MEETING • COLISEUM • NEW YORK • AUG. 24-27

HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

AUGUST 1, 1959

IN TWO PARTS • PART ONE

Theoretical Hospital Administration

41-Bed Intensive Care Unit Is the Heart of Medical-Surgical Care

Employee Orientation: A Channel for Good Will

guide

issue

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HOSPITALS is published the first and sixteenth of each month by the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill. Tel: WHitehall 4-4350. Second-class postage paid at Chicago, Illinois. SUBSCRIPTION RATES: $5 for 1 year; $12 for 3 years. Single copies, 30 cents, except the two-part August 1, Guide Issue, $2.50 (Foreign and Pan-American add $1 per year for postage.) CHANGE OF ADDRESS: Notice should include the old as well as the new address including postal zone number. Four weeks' notice is required. The local postmaster should be notified.

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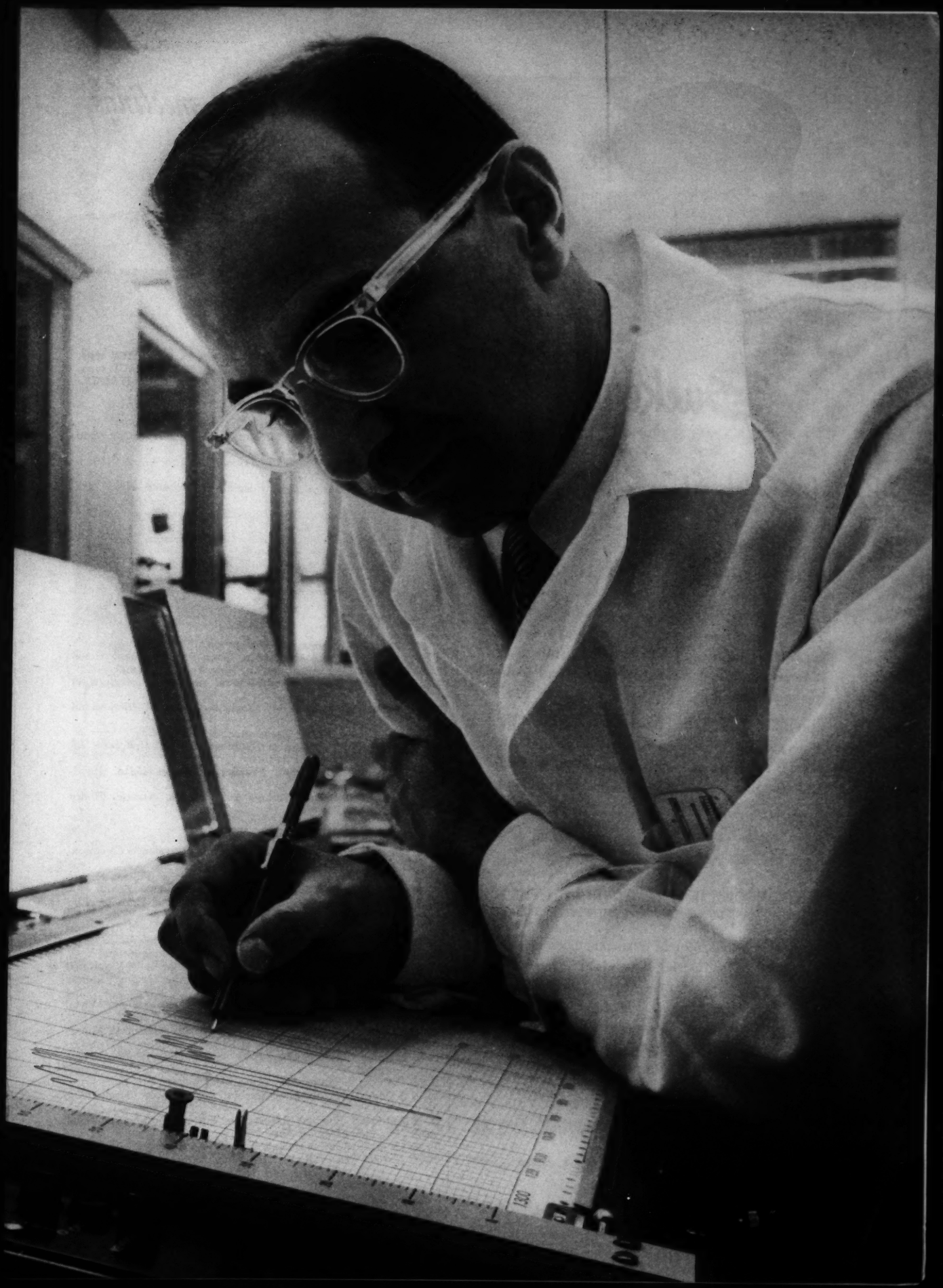

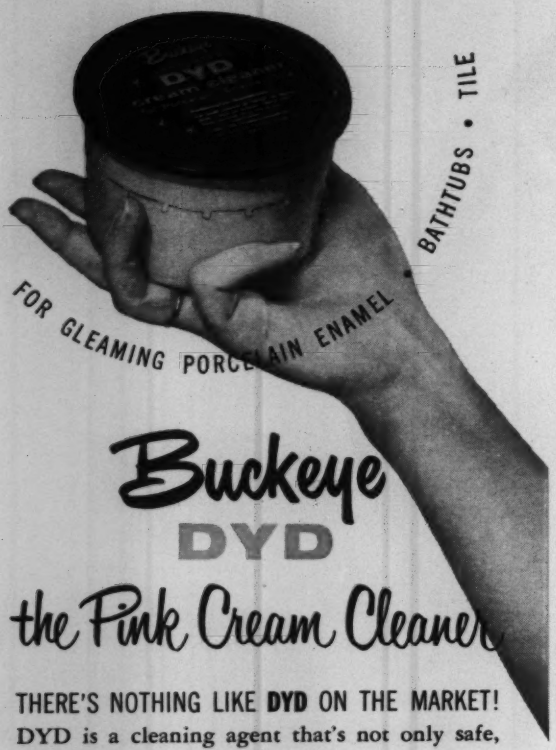

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hospital association meetings

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1959

Aug. 24-27—**61st annual meeting,** New York City (Coliseum; Statler Hilton Hotel)

1960

Aug. 29-Sept. 1—**62nd annual meeting,** San Francisco (Civic Auditorium)

MEETING AND INSTITUTE CALENDAR

THROUGH DECEMBER 1959

(American Hospital Association institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. ***Other organizations in the health field are shown in ITALICS.)***

AUGUST

3-7 **Hospital Pharmacy,** Chicago (University of Chicago)
17-18 ***American Society of Hospital Pharmacists,*** Cincinnati (Netherland Hilton Hotel)
18-21 ***American Pharmaceutical Association,*** Cincinnati (Netherland Hilton Hotel)
22 ***American Association of Hospital Consultants,*** New York City (Statler Hilton Hotel)
22-23 ***American Association for Hospital Planning,*** New York City (Governor Clinton Hotel)
23-26 ***American College of Hospital Administrators,*** New York City (Statler Hilton Hotel)
24-27 ***American Association of Nurse Anesthetists,*** New York City (New Yorker Hotel)
25-28 ***American Dietetic Association,*** Los Angeles (Shrine Auditorium)

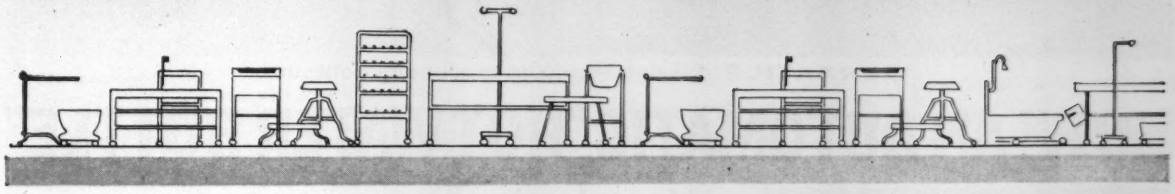
SEPTEMBER

3-9 ***American Psychological Association,*** Cincinnati
14-16 Montana Hospital Association, Great Falls (Rainbow Hotel)
14-18 ***American Dental Association,*** New York (Coliseum)
21-24 **Operating Room Administration,** Denver (Cosmopolitan Hotel)
22-25 ***American Roentgen Ray Society,*** Cincinnati (Netherland Hilton Hotel)
23 Utah State Hospital Association, Salt Lake City
27-Oct. 2 ***American College of Surgeons, Clinical Congress,*** Atlantic City (Convention Hall)
28-Oct. 2 **Housekeeping and Laundry,** Chicago (AHA Headquarters)
28-Oct. 2 **Medical Social Workers in Hospitals,** Atlanta (Henry Grady Hotel)

OCTOBER

1 Hospital Association of Rhode Island, Providence (Sheraton-Biltmore Hotel)
5-8 ***American Academy of Pediatrics,*** Chicago (Palmer House)
5-8 **Nursing Service Supervision,** Boston (Somerset Hotel)
5-9 ***American Society of Anesthesiologists,*** Bal Harbour, Fla. (Americana Hotel)
6-8 ***American Nursing Home Association,*** Chicago (Morrison Hotel)
7-9 **Hospital Librarianship,** Chicago (AHA Headquarters)
8-9 Arizona Hospital Association, Flagstaff (Monte Vista Hotel)
8-9 Colorado Hospital Association, Colorado Springs (Antlers Hotel)
8-9 Mississippi Hospital Association, Biloxi (Hotel Buena Vista)
12-15 **Supervision,** Atlanta (Henry Grady Hotel)
12-15 ***American Association of Medical Record Librarians,*** Minneapolis (Radisson Hotel)
14-15 Indiana Hospital Association, Indianapolis (Student Union Building)
14-15 Vermont Hospital Association, Montpelier
14-16 Saskatchewan Hospital Association, Saskatoon (Bessborough Hotel)
15-16 Nebraska Hospital Association, Lincoln (Cornhusker Hotel)
15-16 Wyoming Hospital Association
19-20 Idaho Hospital Association, Boise (Elks Lodge)
19-20 Oregon Association of Hospitals, Coos Bay

(Continued on page 120)



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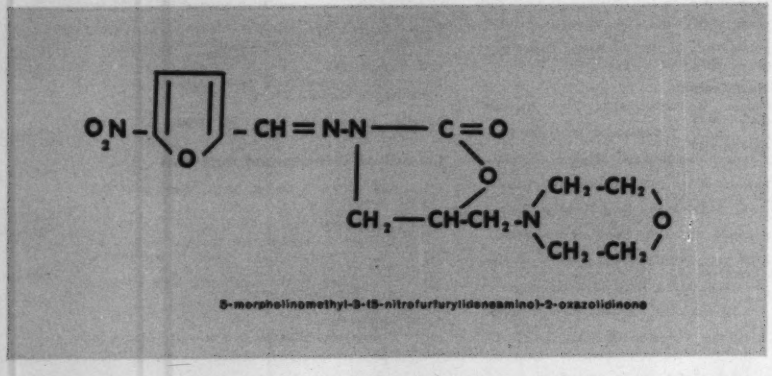

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Streptococci	65	1	98.5
D. pneumoniae	14	0	100.0
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Proteus	5	5	50.0
A. aerogenes	8	0	100.0
Ps. aeruginosa	5	4	55.5

*Includes many strains resistant to antibiotics.

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To date, ALTAFUR has been used most extensively in staphylococcal infections with a cure rate of 66% and an improvement rate of 20%. Of particular importance, a number of these patients had not responded to previous therapy with antibiotics or other chemotherapeutic agents.

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Additional information may be obtained from the Medical Director, Eaton Laboratories.

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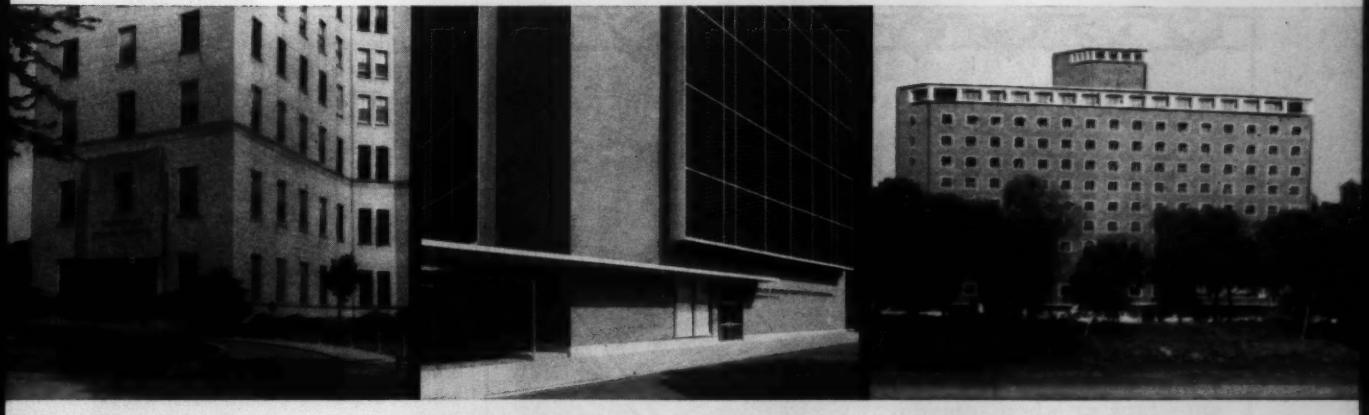

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introducing the authors

Robert P. Brueck suggests the use of the visual color slide film tour of the hospital and a perpetual follow-up recording device as two effective means of orienting employees to the hospital in his article on p. 46.

MR. BRUECK

Mr. Brueck is assistant administrator of Baptist Hospital, Nashville, Tenn. In addition to his activities at the hospital, Mr. Brueck is active in a number of hospital associations and council activities in Tennessee. He currently serves as chairman of the Tennessee Hospital Association committee on safety and as a member of the THA council on public relations and education. Last year he served as secretary-treasurer of the Middle Tennessee Hospital Council.

Mr. Brueck is a nominee of the American College of Hospital Administrators.

Mrs. Mary T. Ancker, R.N., administrator of Lower Bucks County Hospital, Bristol, Pa., discusses the planning, staffing and equipping of the 41-bed intensive care unit in operation at the hospital in an article beginning on p. 37.

MRS. ANCKER

Mrs. Ancker was one of the early organizers of the hospital and its women's auxiliary and served as chairman of the hospital's final fund drive. When the hospital opened in November 1954, she was appointed assistant administrator and two years later was named administrator.

A registered nurse, Mrs. Ancker received her training at Conemaugh Valley Memorial Hospital, Johnstown, Pa. She also attended the University of Pennsylvania and did postgraduate work at Children's Hospital, Philadelphia. She also served as a lieutenant in the Army Nurse Corps.

Mrs. Ancker is a nominee in the American College of Hospital Administrators. Locally, she is active in civic and community affairs in the Bucks County and Philadelphia areas, including the heart and mental health associations.

Anthony J. Maranga, assistant administrator of St. Barnabas Hospital for Chronic Diseases, New York City, describes the portable suction unit in use at his hospital for deterring respiratory distress in pre- and postoperative patients (p. 63).

MR. MARANGA

Mr. Maranga has been associated with St. Barnabas Hospital since February 1954. He joined the staff as administrative resident, following his completion of the academic requirements for a master's degree in hospital administration at Columbia University. He then served as administrative assistant for three years before appointment to his present position as assistant director of the hospital in 1958.

Following discharge from the U. S. Navy in 1945, Mr. Maranga served in various clerical and business office capacities in the U.S. Public Health Service Hospitals in New York prior to his appointment as financial management officer of the PHS Hospital in Cleveland in 1952.

He is a member, American College of Hospital Administrators.

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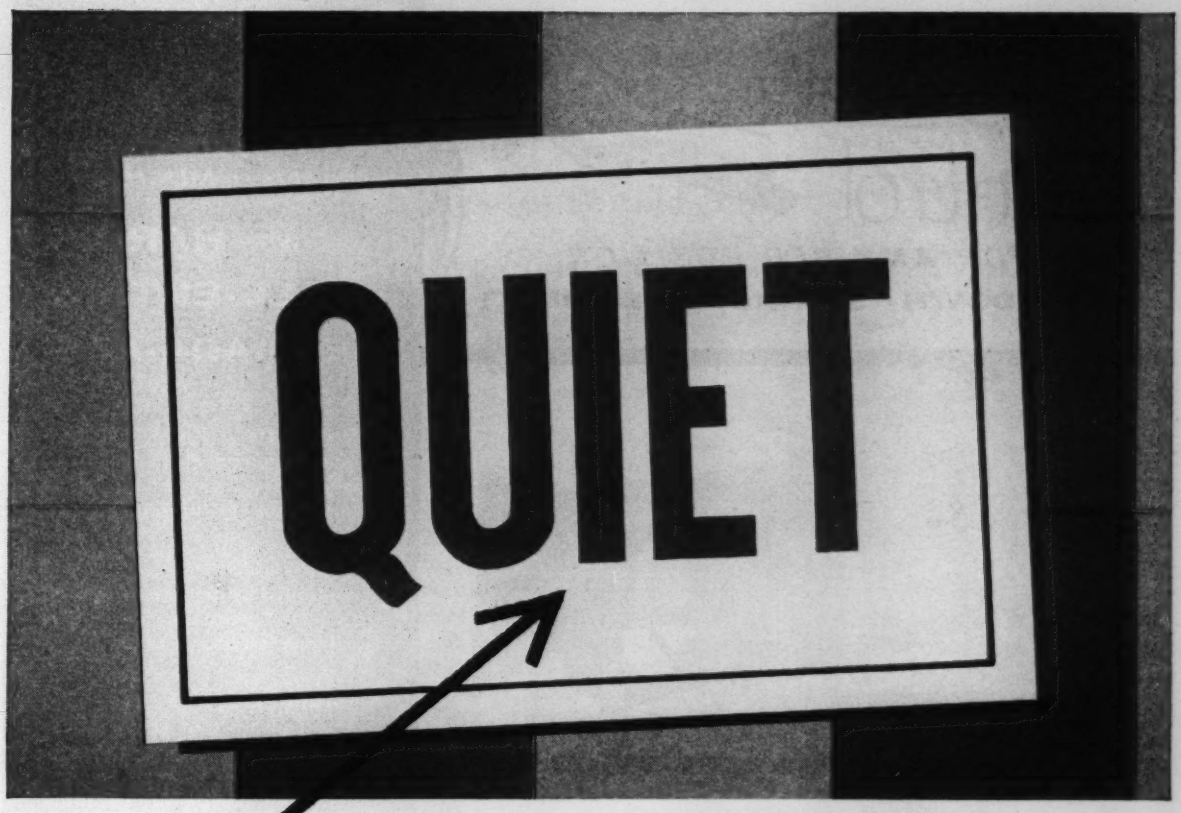

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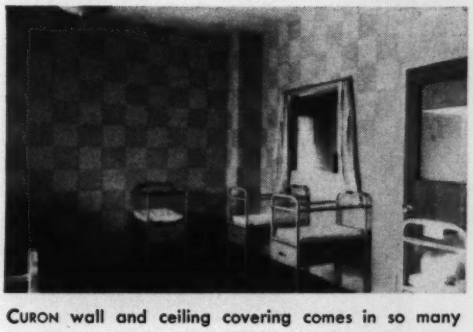

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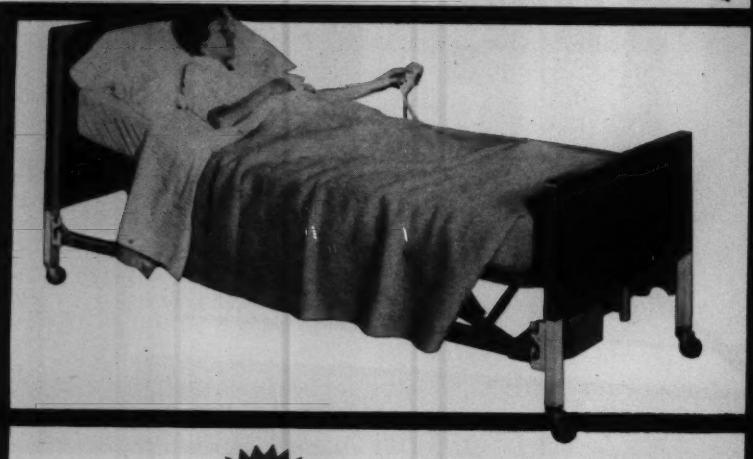

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AHA, AMA Testimony Opposes Forand Bill; Hearings End in Legislative Stalemate

The Forand bill, which would add health insurance for elderly persons through the social security system, has apparently been shelved until next year. House Ways and Means Committee hearings on the bill, held during the week of July 13, were watched closely by hospital, medical and labor groups.

Rep. Aime J. Forand (D-R.I.), who first introduced the bill in 1957, said the hearings were helpful although not complete. "In view of the heavy agenda of the committee," he said, "I don't think we will be able to get this legislation to the floor before adjournment this session". He was hopeful of action early next year.

The third day of the hearings featured testimony by the American Hospital Association and the American Medical Association.

Both AMA and AHA testified in opposition to the bill's provisions for hospitalization and medical care for OASDI beneficiaries.

Testifying for AHA, Frank S. Groner, administrator of the Baptist Memorial Hospital, Memphis, Tenn. said, "The Association is in opposition to the use of OASDI as a mechanism to finance the hospital needs of the retired aged at this time".

Mr. Groner outlined three dangers inherent in the use of social security mechanism which he said, were "of such consequence that it causes us to have serious misgivings with respect to a compulsory health insurance program even for the retired aged."

MR. GRONER

Mr. Groner listed the three dangers, as follows:

1. The government as a purchaser of so much hospital care would exert the power of the purse in ways detrimental to the interests of hospital patients.

2. There is a real danger the provision by government of prepaid hospital benefits would lead to overutilization that could not be controlled and thus to run-away costs, with consequences that could be disastrous to hospitals and the public.

3. The acceptance of compulsory health insurance for one group of the population would foster its extension to other groups, and perhaps ultimately to the whole population.

Mr. Groner urged the committee to delay action on HR 4700, ". . . in the interest of obtaining greater experience in order that we may base final decisions upon the results of experimentation, study and research that is now in process."

AMA's presentation was highlighted by a report on the medical profession's recent actions to further care of the aged, and by documentation of the effect HR 4700 would have on medical care.

Dr. Leonard Larson, Bismarck, N. Dak., chairman of the board of trustees of AMA, opened testimony with the statement that AMA was "making good" on its pledge to the house committee last year that it would continue efforts to improve care of the aged. Dr. Larson said, "The progress of Blue Cross and Blue Shield is only part of the story. An ever-increasing number of private insurance companies are now making initial coverage available to those over 65 on an individual basis and, at the same time, improving the type of health insurance coverage provided." He maintained these "gains would be nullified" by passage of HR 4700.

Dr. Frederick C. Swartz, Lansing, Mich., chairman of AMA's Committee on Aging, declared, "... the AMA has never opposed the Social Security Act per se. HR 4700 is, however, a major and dangerous deviation from the original concept of the system . . . Care for any segment of our population . . . requires flexibility of medical technique, an ingredient which would unquestionably vanish the moment government establishes a health program from a blueprint calling for mass treatment. . . ."

Dr. Swartz contended that ". . . the federal government would control disbursement of funds; determine the benefits to be provided . . . set the rates of compensation for hospitals, nursing homes, dentists and physicians . . . audit and control the records of hospitals . . . and promulgate and enforce standards of hospital and medical care." See earlier story page 103.

● Unexpected early passage of federal employees' health legislation by the Senate has renewed hopes that a government-wide hospitalization and medical program for federal workers may become law this year. However, these hopes dimmed somewhat as house hearings opened July 21 under chairmanship of Rep. Tom Murray (D-Penn.) of the House Post Office and Civil Service Committee. The opening statement of chairman Murray gave doubt that rapid action could be expected. Rep. Murray said he intended to hold extensive hearings.

● Nonprofit hospitals continue to be exempt from provisions of the Fair Labor Standards Act. However, voice vote of the Senate Labor Subcommittee extended coverage of the Act and also provided for certain establishments operated by some hospitals including pharmacies, gift shops and coffee shops. Details on page 104.

● Congress has extended for five more years the federal traineeship awards to professional nurses, although it is not yet known how much money will be available. Details on page 105.

● After Congressional authorization of the professional nurse

traineeship program, the Public Health Service's Division of Nursing Resources announced a new program of short-term traineeships for nurses in supervision and administration. Details on page 105.

EXTENT OF COVERAGE EXAMINED AT HOSPITAL-BLUE CROSS RELATIONS CONFERENCE—The National Conference on Hospital-Blue Cross Relations in Chicago last month featured discussions led by representatives of government, hospitals, the press and the public at large. Among contentions voiced at the meeting were that Blue Cross should not become merely another insurance company, that insurance programs should cover a larger part of the country's health bill, and that only government can provide for certain health needs of the nation.

Studies on the best methods of covering care needs were called for and coverage experimentation was recommended.

Concern was expressed over the close relationship of Blue Cross and hospitals—a close relationship not necessarily viewed with favor by the public. Readjustments in the relationship were suggested as was the importance of assuring the public that they were paying for something of value.

The government's role in health and prepayment was also discussed. The notion that the government alone can perform certain functions in this area was agreed upon as was the idea that the government's role is to supplement, not supplant, the voluntary hospital and prepayment system. Details on page 107.

CALIFORNIA HOSPITALS AIM FOR UNIFORM RATE-SETTING METHODS—Uniformity in the method and basis of establishing hospital rates is the aim of a program begun last month in Southern California under the auspices of the Hospital Council of Southern California and its eight area councils. The president of the council stressed that the code adopted does not seek to establish prices nor does it guarantee that charges will be uniform in all hospitals; it is designed, in part, to aid the patient in understanding hospital bills and to provide an opportunity to compare costs.

The council's code divides specific hospital charges into eight categories and includes recommendations for procedural efficiency. It covers such subjects as the objectives of the hospital, duties of the governing board, organization of medical staff and admitting procedures. The code also includes recommended hospital operating ethics. An eight-member grievance committee has been established in conjunction with the program. Details on page 108.

GRANT WILL FINANCE ACCOUNTING AID TO SMALL HOSPITALS—The Hospital Research and Educational Trust has received an $81,890 grant from the W. K. Kellogg Foundation for the purpose of helping small hospitals improve accounting procedures. Dr. Edwin L. Crosby, director of the trust, said the grant will finance the Hospital Administration Services project of the trust until July 1, 1960, in Colorado, Nebraska, and South Dakota. Details on page 114.

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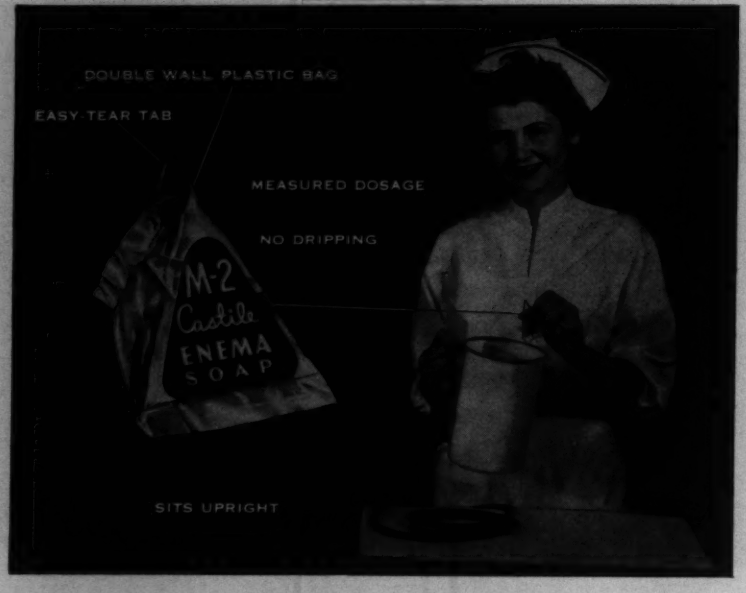

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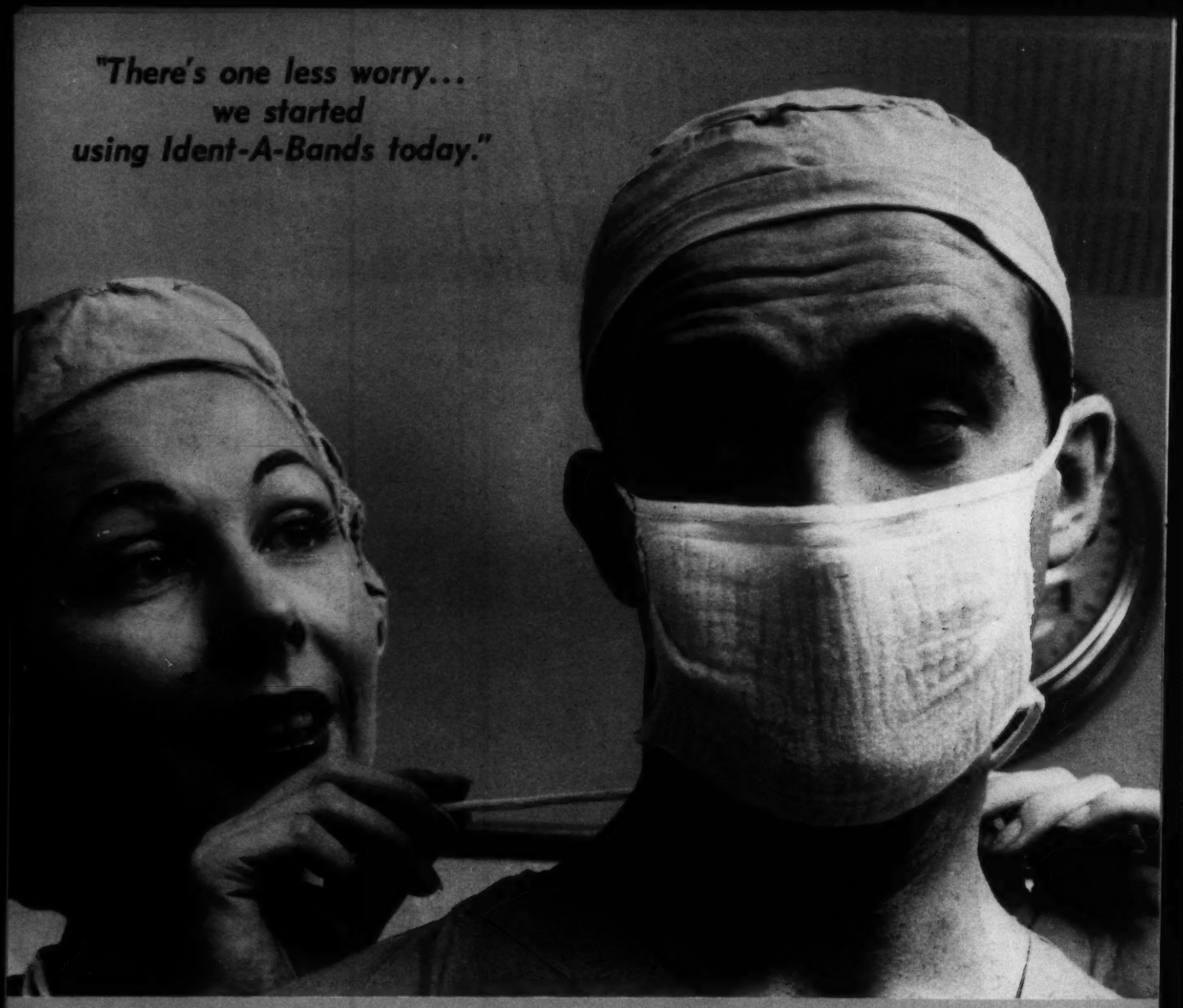

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Mobile radio system improves patient care

A new mobile radio system that may eventually lead to a statewide network of radio communications between hospitals and doctors is now in operation at the 210-bed Robeson County Memorial Hospital, Lumberton, N.C. This radio system will not only play an essential role in times of disaster but it serves daily in improving the care of emergency and maternity cases, reports Hospital Administrator J. M. DeVane.

Believed to be the first of its kind in the nation, this mobile radio system includes 32 units—26 doctors' cars and 6 ambulances.

"When ambulances pick up injured patients, they radio in to the hospital so that we can be prepared for them," Mr. DeVane said. Also, staff physicians making house calls anywhere in the county can radio the hospital to check on available bed space and make arrangements for admission.

Busy physicians with patients in the hospital can make their house calls and still remain in constant contact with the hospital. "To improve the coordination between delivery suite and the obstetricians, we are installing a speaker in the delivery suite so that the doctor can talk directly with the nurse about his patient's condition," Mr. DeVane reports.

Radio transmission carries 35-40 miles between the hospital and the cars and 10-12 miles between cars. The hospital and the doctors are using the same basic code system as the law enforcement groups but are on a different frequency.

In addition to the radio communication in use between hospital and doctors, there is also direct communication with the Civil Defense Director's office which in turn is connected with the fire and police departments.

The cost of this radio system was $20,000, of which the doctors paid half and the local Civil Defense organization paid half. Mr. DeVane reports that the success of the Lumberton installation has prompted interest in installation of a statewide network of radio communications among hospitals. One reason for this is that most hospitals have auxiliary electric generators which may be used whenever public utility power is cut off. In a major catastrophe, hospital radio transmitters might be the only ones functioning. ■

Miniature orchestra amuses, educates young patients

Preparation of a scale-model symphony orchestra was a recent project undertaken at Martland Medical Center in Newark, N.J., to educate and amuse pediatric patients with long-term hospitalization. This project is an out-

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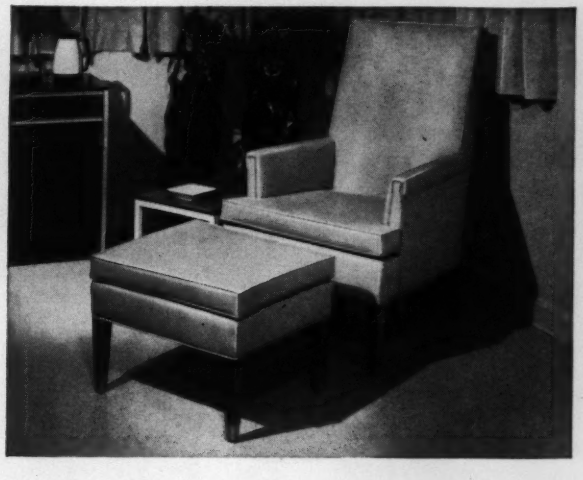
growth of the music appreciation course offered to young patients in cooperation with the Newark Board of Education.

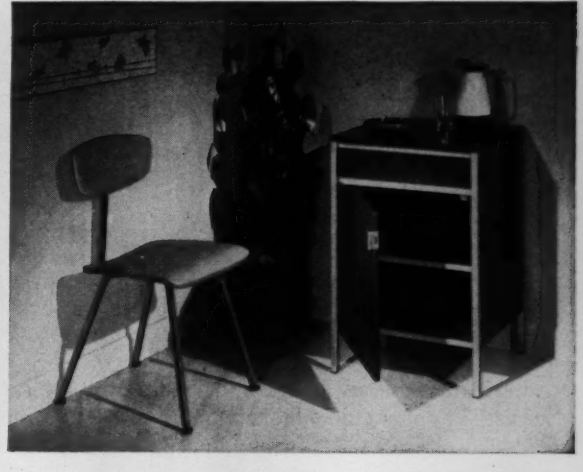
The miniature orchestra, featuring 39 musicians and a conductor, is the result of the combined efforts of pediatric patients at the Center. A wide assortment of materials was used in making the figures and instruments. The musician-models are formed of modeling clay and plastic and wired to maintain their shapes. Instruments are made of balsa wood and scraps of other materials. Toothpicks serve as bows and gilded clay makes up the brass section.

The harp is made of a dowel stick, cardboard and tongue depressor cut in half. The strings are sewn in by hand. A pill box serves as a base drum and bits of adhesive tape on wood form the music stands. The manual training class at a local school made the stage.

In evaluating this type of program for the hospitalized child, Abraham G. Chmelnik, M.D., the hospital's medical director, and Mrs. Molly L. Stern, instructor, called "this handiwork highly therapeutic." A child's recovery is speeded when he is happy and has something vital to do. Mrs. Stern also reports that former pupils frequently inquire about the progress of the project after they have gone home from the hospital. ■

CLAY, plastic, wood and other materials were used by young patients at Martland Medical Center in Newark, N.J., to fashion the models and instruments for their miniature symphony orchestra on display in their school room. The symphony conductor, being placed on the podium in the photograph above, has been fashioned from modeling clay.





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Utility becomes beautiful in this new Vivant hospital bedside cabinet (F-16340-115) by Simmons. Its top, front and sides are sheathed in Fiberesin—the "peopleproof" wood-grained phenolic laminate. Rough treatment cannot hurt this surface—can't dent, split or abrade. Even fruit acids, grease, alcohol, fingernail polish or forgotten cigarettes cannot damage it. Side chair (FC-786-303) has upholstered seat and back in Doe-Vin Naugahyde.

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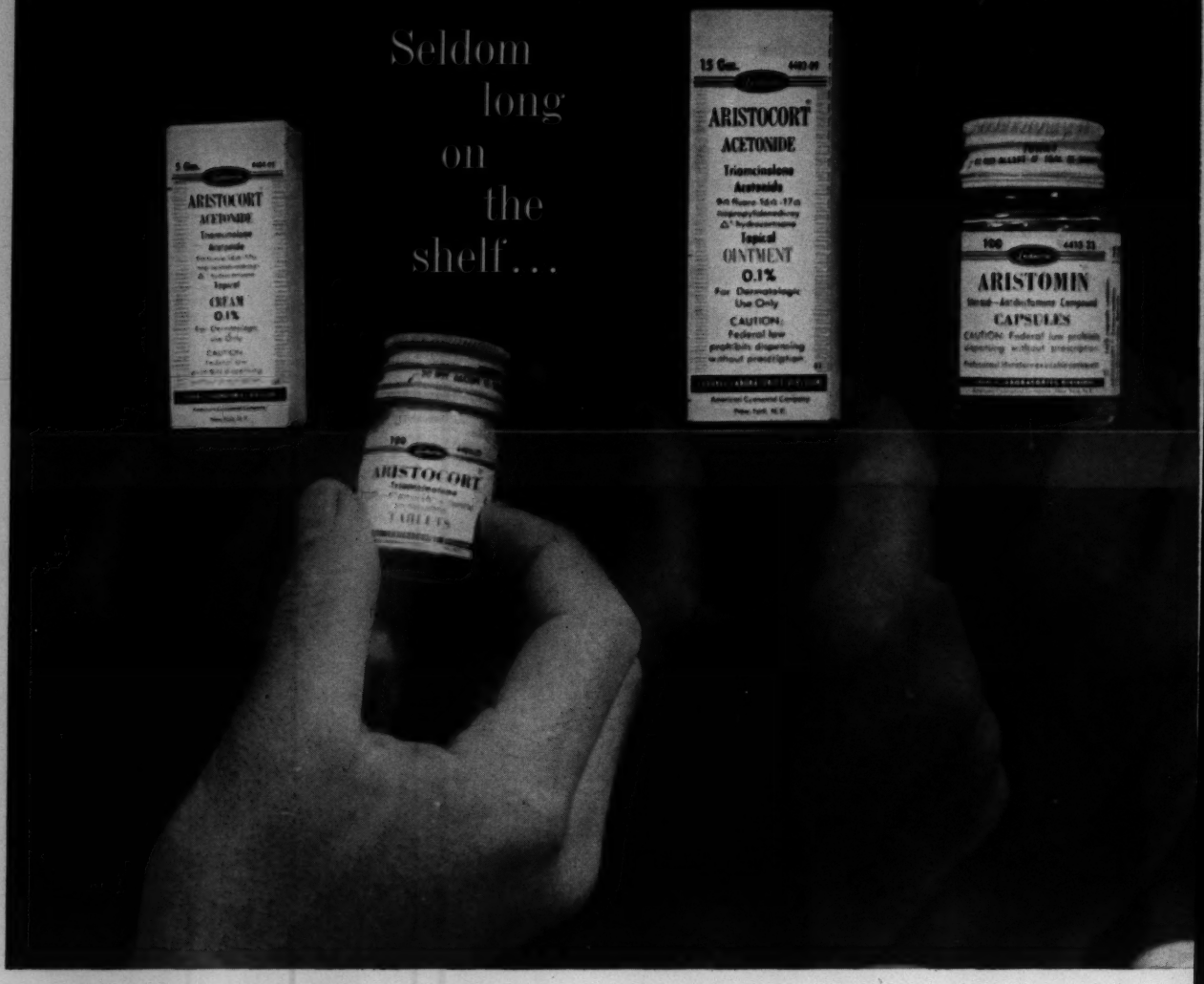

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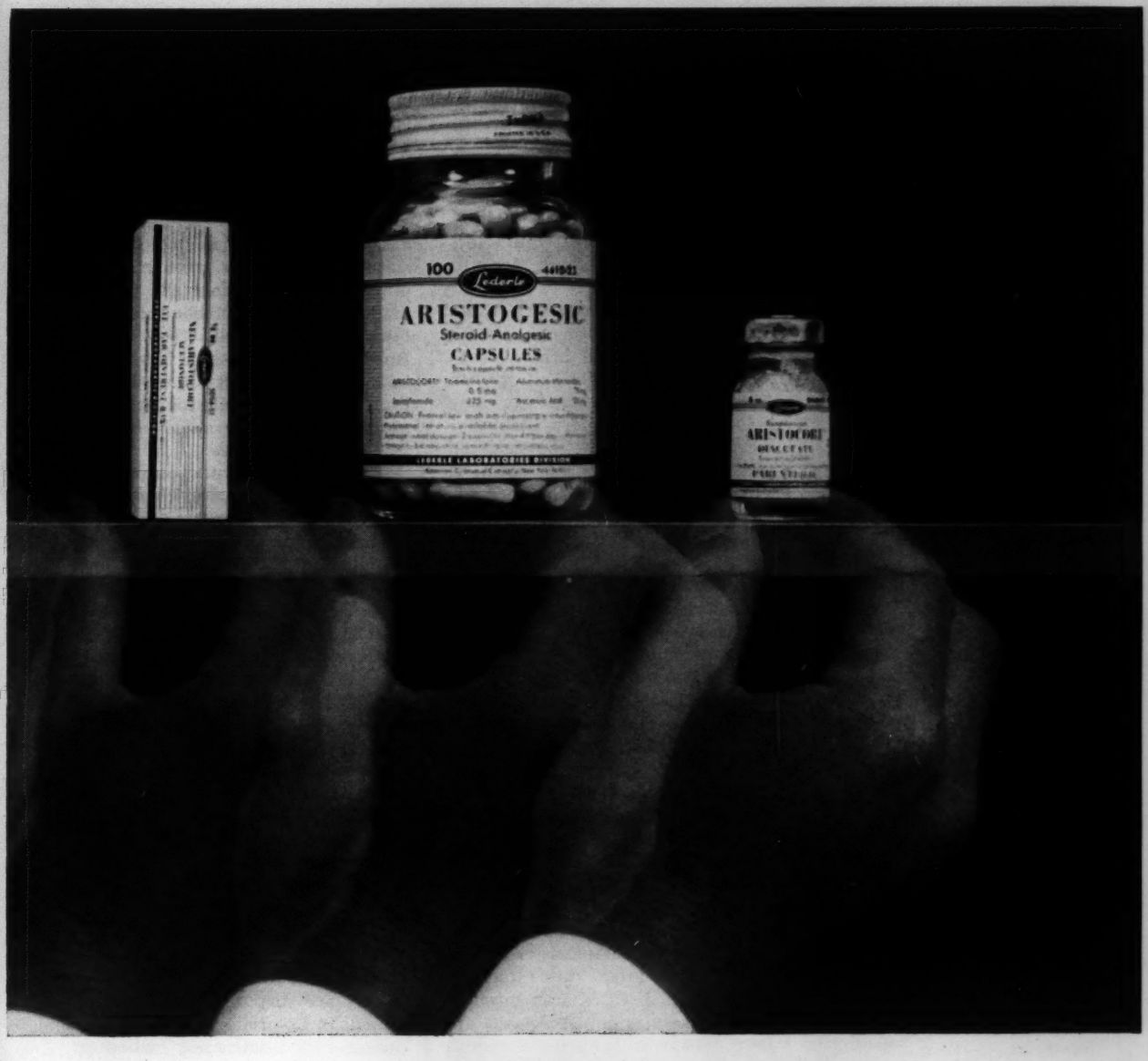

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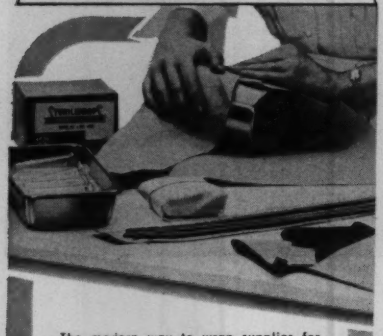

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Infections in pediatrics

What information or references can you give on dividing pediatric wards to fight cross-contamination?

We have done some research on recent investigations into this problem and hope our findings will be helpful.

In 1958, the New York State Department of Health published a booklet, "Control of Staphylococcal Infections in Hospitals", in which the following appears: "Any individual with overt staphylococcal disease must be isolated preferably in a separate room. If this is not practicable, and the patient must remain in a room with others, not so infected, extreme precaution to protect against cross-infections must be exercised. A corner of a ward can be arranged by screens or curtains so that an isolation cubicle is in fact designed. The area can then be subject to those techniques of isolation which allow individual care to the patient without endangering others." This booklet is available from the New York State Department of Health, 84 Holland Ave., Albany 8, N.Y., for 50 cents.

The "Guide for Prevention of and Control of Infections in Hospitals", published jointly by the New York State Department of Health and the American Public Health Association, states that patients with diseases transmissible through respiratory secretions are best cared for in private rooms, but if it is necessary, they may be grouped by diseases in wards. Even then it is preferable that each be in separate permanently walled cubicles. I would say this means that the partitions should be the full-height, rigid type. Copies of this guide may be obtained from the Health Education Service, P.O. Box 7283, Albany 1, N.Y.

—ROGER MELLEM

State labor relations laws

In reviewing Personnel Relations Series No. 2 "Hospitals and Employee Groups" (page 9), published by the American Hospital Association, I find myself interested in learning the identity of the states or territories which now have labor relations acts to cover segments of the business field, specifically nonprofit hospitals, which are not subject to federal labor laws.

The four states in which the statutes specifically exempt voluntary hospitals from the jurisdiction of the state labor relations laws are Connecticut, New York, Rhode Island, and Utah. The state in which the courts have interpreted the labor relations statute as not covering charitable hospitals is Pennsylvania.

Three states have special provisions in their statutes. These are: Massachusetts—the act makes provision for inducing settlement of disputes in hospitals. Strikes are not allowed but government seizure is possible; Michigan—the statute requires the maintenance of the status quo during investigation of labor disputes affecting hospitals and the courts may enjoin a strike during this period; Minnesota—the statute makes strikes in charitable hospitals unlawful and also in nonprofit state, county and municipal hospitals, but it also creates a compulsory arbitration procedure.

In Wisconsin, the labor relations statutes apply in full to voluntary hospitals but the courts have indicated that interruption of the hospital's operations as the result of a labor dispute might be enjoined. In Colorado, litigation is in progress to determine whether hospitals are covered by the state labor peace legislation.

—ARTHUR H. BERNSTEIN

The medical library

Would you please send us a list of recommended books for a medical library? Is there any policy regarding removal of outdated books from the shelves? How long should journals be kept?

There is no one recommended list; the services and needs of the individual hospital and its medical staff must be reflected in current periodicals and basic standard texts. You will be interested in knowing that the library of the American Medical Association

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

is currently working on a revision of its suggested readings for medical libraries which will be ready by October, when the American Hospital Association is conducting an institute on hospital librarianship.

Because medical knowledge is constantly expanding, there is little value and sometimes real danger in keeping shelves filled with old editions and obsolete textbooks. If you plan a historical collection and have the space, you may wish to keep outdated books. But for a live, working collection, my recommendation is a firm discard policy.

The length of time journals are kept should be determined by the needs of your staff and the resources of other libraries in the area. If you can rely on a county medical society library or a medical school library for interlibrary loans, then journal runs of five years would be adequate, although my personal preference would be ten years. However, other local medical library resources do not relieve the hospital of its responsibility to maintain a medical reference library for its own staff.

—HELEN YAST

Administrators' contracts

I would like to know the prevailing practice regarding terms of administrators' employment. Do most hospitals annually rehire the administrator? Or, after he has successfully worked for a year or so, do most governing boards assume that he has tenure? In either case, is a written contract the rule or the exception?

By and large, most administrators are not employed under a contract. While there are no statistics available on this subject, we have found through management audits conducted by the Hospital Counseling Program that nearly all of the administrators in this audit did not have a contract. General practice seems to be that there is an original letter from the president of the governing board employing the administrator and that nothing is stated as to conditions of termination or any termination date given on the original letter, which is really one of intent of relationship between administrator and hospital. Governing boards assume that

(Continued on page 121)

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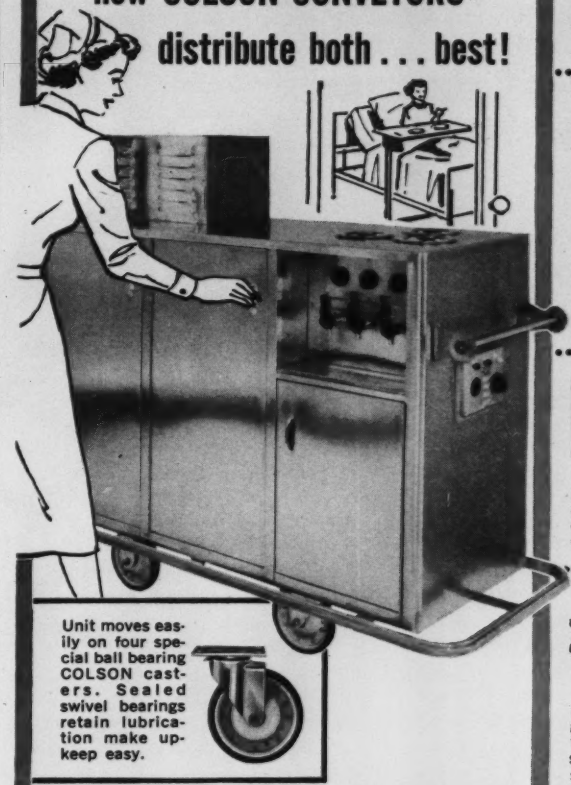

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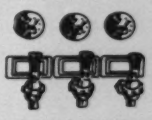

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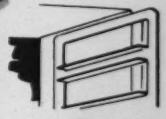

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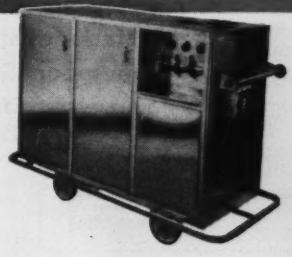

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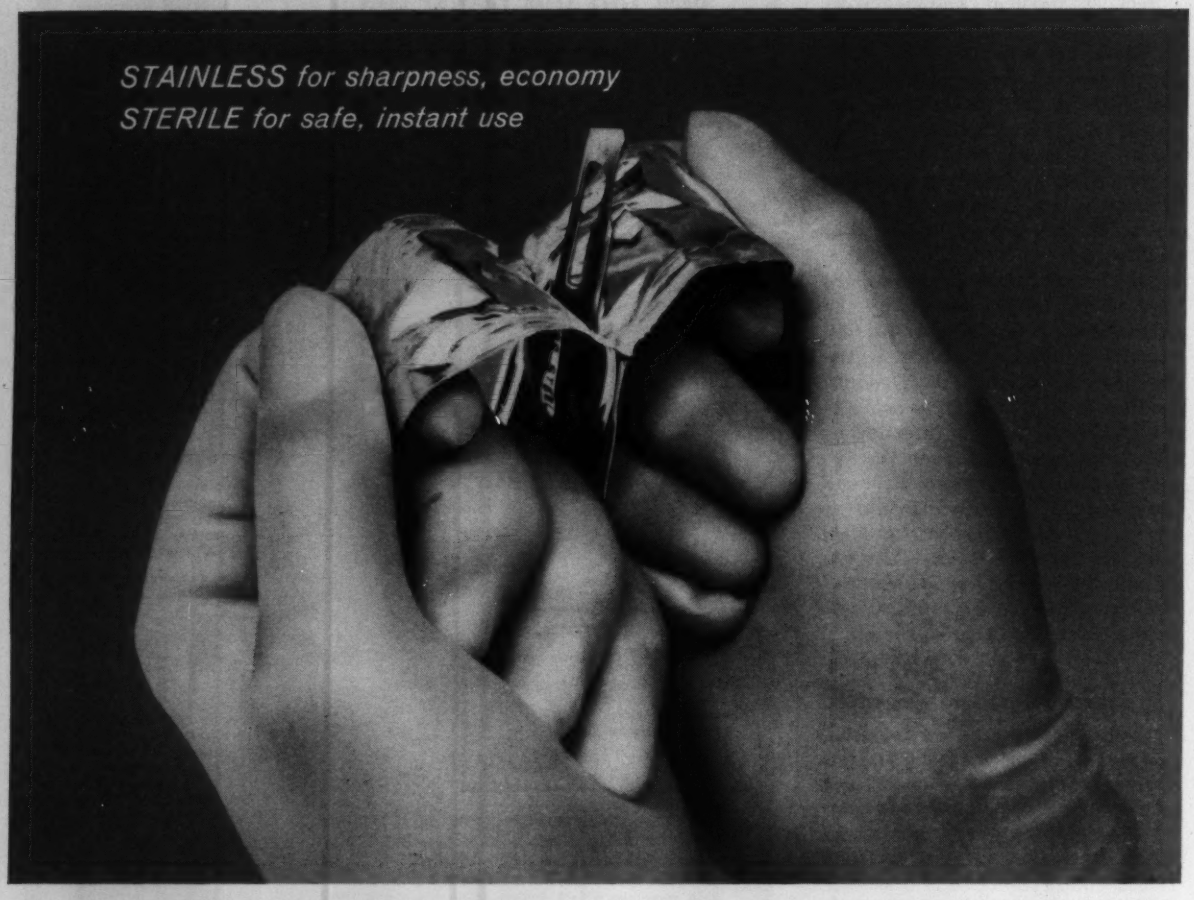

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HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—where will they all go?
—who will take care of them?
—who will pay the bill?

IF THE demographers are right, world population will be 4 billion persons by 1980, 6 billion by 1999. At the beginning of the Christian era, world population totaled 250 million; in 1650, the start of the modern era, it totaled 500 million; and, in 1950, it had increased to 2.5 billion.

A steady increase in the rate of growth of world population in the modern era accounts for this "population explosion", as the demographers call it. Between 1900 and 1940, the rate of increase was less than 1 per cent per year; in the decade of 1940 to 1950, it rose to 1 per cent; since then, it has risen to 1.7 per cent. This rate of increase adds 47 million people to the world population every year.

The major reason for this "population explosion" is the reduction of the death rate. Until recently, the birth rate has remained relatively stable throughout history. However, since fertility minus mortality equals rate of natural increase, any change in either fertility or mortality rate will affect the rate of increase.

Modern medicine and hospital care have dramatically reduced the death rate and, in so doing, have largely contributed to the "population explosion". This reduction is a striking tribute to the efficacy of both disciplines, but its consequences pose complex problems for medicine and hospital administration to solve in the future.

Some of these problems may be stated as questions.

1. If the population of the United States continues to grow at its present rate of 1.7 per cent per year, what will be the effect on the building, operating, staffing and financing of hospitals?

2. If, in spite of the present rate of construction of hospital facilities, twice the present facilities are needed to adequately care for our present population, can the rate of construction be raised to provide adequate care for an increasing population?

3. If the rate of construction can be raised to the desired level, can such construction be financed?

4. If such construction can be financed, can sufficient personnel (professional, trained and untrained) be recruited to staff the new facilities?

5. If present trends in hospital utilization continue, what effect will a burgeoning population have on hospital income and prepaid insurance?

6. What effect will all these factors have on the quality and scope of hospital care?

These are the questions—you must help answer them.

OFFICIAL NOTES

Actions taken by the board of Trustees of the American Hospital Association at its meetings in Chicago, May 18-19, 1959, are reported in this issue in the Association Section on page 54.

—a lode of hospital facts

THIS IS the two-part Guide Issue of HOSPITALS, J.A.H.A., annually our biggest publication endeavor.

One traditional trick for demonstrating magnitude is to say that, for example, this cable or that rope, if untwined, would belt the earth at the equator. All of the sheets that go into all the copies of Part 2 of the Guide Issue would go a long way—a ribbon of paper 8½ inches by some 1200 miles—but wouldn't girdle the equatorial earth.

And it really doesn't matter. What does matter is that Part 2 is the richest lode of hospital facts in existence.

One section profiles every listed hospital—bed capacity, census, admissions, personnel expenses, facilities, address, and even the telephone number. The statistical table puts together in usable fashion much of the vast quantity of data punch-carded from the annual survey.

The roster of organizations in the health field and the Guide to the American Hospital Association round out the issue.

Part 2 of the Guide Issue is a ready reference and a reservoir for research. In its pages may be found the facts which will help fashion our future.

THEORETICAL HOSPITAL

by FRANK R. BRADLEY, M.D.

"Theoretical hospital administration" includes a realistic perspective of hospital administration, a unified hospital philosophy and a unified theory of hospital administration, according to the author. The phrase is elaborated by the author as he describes the use of the scientific method of investigating the function and behavior of hospital administration by observation and experiment and the combination of this data with a mental picture of what hospital administration is or should be.

FOR SOME YEARS I have felt an intense need for three things relative to hospital administration:

1. A perspective of hospital administration that has a grasp of reality and includes the administrator in the picture.
2. A unified hospital philosophy.
3. A unified theory of hospital administration.

The administration of a hospital must be the one most capable of evaluating the hospital as a *whole* in its complex interrelationships. Surely today, we recognize that the function of the administrator is to organize and integrate facts from all levels of function within the hospital. To date, we have not been able to qualify for this necessary broad responsibility. To qualify for this task, we need an administrative science with a theoretical background which deals realistically with all types of functions and data.

We are confused and bewildered by the great impact of change on society, medicine, and the hospital. We have moved from a period of relative simplicity, from a reasonably crystallized tradition and stability, into a period of complexity and relative instability. We have lost a great degree of unity. The tendency to disperse, to be distracted, to have friction, to fragment, has undermined tradition and obscured basic principles. We are inconsistent. We have not adhered to basic principles or used our historical perspective and common sense to capitalize on rapid change and improve our position. We are confused and are carrying on what has been described as "crisis administration" and "aspirin problem" solving.

Change and progress continue, surely. There is no doubt that progress requires change, but change in itself is not progress unless it is based on principles and natural laws which themselves are unchangeable. We must, if possible, find those laws. The need is great. There are diversified viewpoints among teachers of hospital administration. There is confusion in the minds of the legal profession and our state legislators as to just what the modern hospital is and does. There is confusion on the part of the medical profession, particularly among the radiologists, pathologists, and anesthesiologists, about their role in the hospital. There is antagonism from nurses' organizations. There is a great clamor from segments of society about hospital costs.

Hospitals will be on the defensive in dealing with their component groups and the public until the administrators can develop a clearer exposition of the hospital as an entity, one that shows its role in society and indicates its relation to its component groups. The hospital must be visualized as a whole, as a complex, major sociologic service organization, as the workshop of the physician that requires numerous personnel to perform many diverse and specialized tasks—all aimed at the primary purposes of diagnosis and cure of disease and injury, clinical research, and graduate education of medical and paramedical personnel.

To facilitate my thinking about the problem of the three needs of hospital administration, I have used the phrase "thoughtful administration". I first mentioned it in the first of my Presidential Reports, in the September 1954 issue of this Journal, and continued to discuss the subject through 1954-1955 in subsequent reports. Since then I have amplified my conception and description of "thoughtful administration" and have found the temerity to develop the term "theoretical hospital administration". "Theoretical hospital administration" is broader than a theory because it includes 1) a concept or perspective; 2) a unified philosophy; and 3) a theory of hospital administration.

"Theoretical hospital administration" is a more descriptive phrase because it describes the use of rational knowledge gained by experience and observation, and the image of the intellect, i.e., concept or perspective. "Theoretical hospi-

Frank R. Bradley, M.D., is director, Barnes Hospital, St. Louis.

tal administration" permits the use of the scientific method of investigating the function and behavior of hospital administration by observation and experiment and the combination of this data with a mental picture of what hospital administration is or should be.

A UNIFIED PHILOSOPHY

The hospital can be viewed as a living organism whose chief anatomical components or parts are living beings, some working, some learning, some residing, some receiving treatment, all in a group environment and under one roof. The hospital has many characteristics of a living person. We can properly call it a biosocial organism. To be active, effective, and self-consistent, this organism must have a motivation. That motivation is the composite motivation of all groups involved—the motivation of patients to seek professional care for diagnosis, cure, and comfort of their illness and injuries; the motivation of the physician who professes responsibility and dedicated purpose to diagnose, cure, and comfort the sick and injured persons; the motivation of the nursing profession, dietetic profession, and other paramedical groups.

Once motivated, we must act. Coordinated effective action requires a natural force. Common consent is that force in our democratic republic. Coercion or dictatorial control is foreign to this philosophy. Therefore, if we thoughtfully consider the building blocks of our unified philosophy, the key to our arch will be the philosophy of choice, of voluntary consent and freedom. It is obvious from our outline of unified philosophy that it is the sum of the philosophies of the social groups whose common needs make the hospital. It is the unified philosophy of the hospital's living parts.

Apropos of perspective, "theoretical hospital administration" applied in an active, critical, and common sense approach to the study of the hospital shows the hospital to be literally a living indivisible, social organism, a unit of society which somehow functions as the whole of its parts. A hospital is a socially evolving, experimental biosocial operation; its personnel have a multirelational character and are themselves constantly changing and experimenting. These groups appear in a state of flux which in turn creates different patterns of flux in the whole hospital.

Under ordinary principles of administration and structure that are found in the traditional business organization, the hospital is an anomaly—a paradox. It should not be able to function, but it does. The constantly changing hospital not only operates, but surprisingly, maintains a reasonable, orderly, internal and external structure and function. True, the hospital varies according to its own complexity and the situations to be faced, but it is an extremely versatile entity with a wide range of different capacities and functions. It is a center of relative, but definable, spontaneity and responsiveness. It is a service institution which, because of a common need and common consent, is more or less independent and autonomous. To remain independent and autonomous it cannot be regulated by some other agency or power. It cannot be fragmented.

Let us see if history can add to our perspective. The modern hospital evolved without a unified theory, without a unified philosophy. Its evolution followed natural laws (of which we are more or less ignorant) and was stimulated by the common need of society, and the vastly increasing scientific knowledge in medicine, later, by population growth, changes in modes of living and improving economic life. It did not evolve because of any coordinated control or planning by society, the medical profession, governing bodies, or administration. It simply grew. We have planned, but only as fragmented groups within professional associations such as the American Hospital Association and American Medical Association. Governing boards within individual hospitals have planned, but there has been little coordination.

Only within the last decade or two has there been an attempt on the part of outside organizations or forces to integrate or control the hospital.

Can we now outline our thesis? Yes, we can see enough of the picture to give us a theory, crude as it is. We have outlined the structure of a unified philosophy, we have gathered considerable perspective, and it brings us to the thesis that:

1. The hospital is a living organism and, therefore, falls in the realm of natural science. It is a social organization and, therefore, it falls in the realm of social science. The term, biosocial, is used to apply to the living, active, semi-independent, autonomous, service institution we call the hospital.

2. It is a living organism and if there is no action there is no life. It therefore follows that the

essence of the hospital is action. The essence of administration is action, both intellectual and managerial. Time continuity is essential to understanding the true dynamics of the hospital.

3. This living organism has a life term that may cover several centuries. Its group components have life cycles of usually between two and three decades. The average minimum cycle of time that is meaningful enough to study and interpret larger units of hospital administration and behavior is one decade. By larger units is meant complete acts which may last for months or several years.

ANALOGY DEVELOPED

Our theory that the hospital is a living, biosocial organization is far different from the concept that the hospital is primarily a social environment. It is true that the hospital provides a definite internal environment and a far more indefinite external environment. The internal environment is for its components who work, learn, and are treated in the hospital. The external environment is for those who visit, support, and are interested in the hospital; those agencies or businesses working with or for, and selling to the hospital; the governing board, women's auxiliary, and the like. The walls of a building are similar to the external or outer skin of the human body. The walls enclose the various groups making up the hospital and the skin covers the various organs making up the body. In turn, the hospital groups are composed of specialized personnel and the body organs are composed of specialized groups of cells.

There are other parallels. Where, in this biosocial organism, is the brain, the central nervous system with its motor and sensory nerves? Where is the autonomic nervous system with its sympathetic and parasympathetic nerves? Like a nation, a school, a church, the hospital has a personality. All operate as a whole of their parts. We have said that the hospital surprisingly maintains a reasonable orderly function and relative, but definable, spontaneity and responsiveness. In a collective sense, it has a consciousness. Its brain is the composite brain of the leaders of its components. Its central nervous system is its formal communication. Its autonomic nervous system is its informal communication. Our thesis about the brain of this biosocial organism cannot be objectively explained any more than we can objectively explain gravity. But the personality, the spontaneity, the responsiveness of a hospital, and the feel of the pull of gravity are both easily observed.

PERSONALITY AND ACTION

We have said in our theory that the essence of the hospital and of hospital administration is action. Let us support that statement. We are dealing in this biosocial organism almost entirely with human animals. Action or motility, the capacity for spontaneous movement, is one of the distinguishing characteristics of animals; the capacity for spontaneous movement enriches the adaptive resources of the organism. The simplest type of motility is characterized by specific structural-functional sensitivity which we call reflex. It is an immediate reaction to stimulus in time-space continuity.

In a hospital there has developed a segregation of function and specialization of stimulus to and response by its component groups. This has created formation of independent sensory and motor functions. What we call a delayed reflex becomes possible usually at the informal communication level. Some of it is subconscious.

A third type of specific organization, which we think is a process of adaption, is the development of sensitivity to symbols or word-function which leads to formal organization charts and formal communications, always at the conscious level. As hospital administration and hospital function become older, more traditionalized—and this includes their component professional parts—the more highly differentiated organism is able to organize direct experience, imagination and previous experience of function towards awareness (which some call orientation). Planning is now made possible by the ability to anticipate trends of thought and reasoning; planning is stimulated by the feeling and striving for higher standards.

The organism now reacts with consciousness, a special mental method that includes space and time relations in the life of groups of individuals working together. Through the repetition and traditionalization of hospital function, through the more or less orderly blending of actions of the component parts, the organism builds up a temperament, a personality, and a character. Through the integration of its component parts, its philosophy, its differentiated sensibility and motility, the biosocial organism presents a personality characterized by varying degree of plasticity with an underlying consistency. In the tremendous expansion and differentiation that the hospital organism is now capable of, factors can be observed that tend toward unity and continuity. We have an organism that organizes itself, at least its own nature and the resources of its setting. We have a functioning that we can finally designate distinctively as voluntary functioning.

COMPLEMENTARY MUTUAL ANTAGONISM

Several postulates and laws that are necessary adjuncts to our theory shall now be mentioned. The first one that we discuss is the law of complementarity. Neils Bohr was the first to observe in the field of quantum physics the antagonism in the dual concept of light as quanta of matter, having mass, and the concept of light as a wave phenomena. He stated that it is necessary to conceive of both. They are "complementary" in that a complete description of observable phenomenon of light requires that the corpuscle and the wave idea be employed in turn—that these concepts are irreconcilable and the images that they furnish are never simultaneously applicable. The principle of complementarity can be stated as follows:

> Complementarity functions are in a sense irreconcilable and mutually antagonistic.

It is an observable fact that the following complementary functions in the hospital are mutually antagonistic; preventive, curative, and restorative medicine; group insurance with a philosophy of function of selling and advertising to prospective patients and the philosophy of medicine that is opposed on ethical grounds to selling and adver-

tising. A mutual antagonism exists between the professional groups in the hospital whose functions are complementary; the mutual antagonism between the patient and his disability and disease is most important and cannot be overlooked in any consideration of the hospital. Last but not least, a mutual antagonism exists between personnel and administration.

An awareness of this mutual antagonism as a constant factor provides the administrator with an explanation of many hospital difficulties. We are not taken by surprise when frictions arise between complementary groups. To understand these antagonisms suggests a method of overcoming them. We can anticipate and thereby either prevent or minimize frictions.

How do we overcome this mutual antagonism? The natural force of common need brings common consent of the social groups of the hospital and causes them to submit somewhat to the coordinating influence of administration and accept its help. It is not a simple task in view of the complexity of the hospital. "Hospitals are loosely integrated organizations made up of semiautonomous professional groups, highly individualistic, highly motivated, jealous of their status and loyal to the character or ethics of their profession. The degree of cooperation between these semiautonomous professional groups who work in the hospital depends upon their understanding, mutual interest, needed common service, and assistance, knit together by informal arrangements, committees, treaties, and common interests."[1] We cannot escape the conclusion that the hospital is a loosely knit organization as far as the professional groups are concerned.

COMMON NEED AND CONSENT

We have yet to consider the common need and common consent of patients, their friends and relatives, and the community. There is no doubt of the individual patient's need for medical care. More than one out of eight people enter a general hospital each year. Over 95 per cent are born there. The question of common consent is an interesting problem because it brings into consideration the fact that the patient makes a contract with the physician—definite and specific if with a private physician, and just as definite but not quite so specific if with a physician in a teaching or governmental hospital. The doctor in turn makes a contract with the hospital for the right and privilege to use the hospital as a full-time physician or as a workshop for treating the patient. The patient also makes a contract with the hospital for hospital services which ordinarily do not include medical services. In addition, about 70 per cent of the population are covered by some type of hospital and medical insurance; therefore, there is a fourth contract with the insurance company who in turn may—and this is particularly true of Blue Cross—make a contract with the hospital.

The degree of common consent is closely dependent upon motivation but it is also dependent upon give and take, which can best come from understanding the role each complementary group plays. Certainly it includes each group's acceptance of a unified philosophy that relates to the hospital's primary purposes and the philosophy of the other component groups. The philosophy of hospital administration must relate to the philosophy of medicine and to the philosophy of the primary purpose of the hospital. The philosophy of medicine must relate to the philosophy of administration and the hospital. To obtain this reciprocal acceptance on the part of the component groups requires understanding. Understanding calls for exposition, explanation, teaching, and interchange of ideas. In two instances at least, in the emerging profession of nursing and the relatively new profession of hospital administration, a better definition of the real function and philosophy of the profession is needed.

Motivation also tends to bring unity. The principles of unification is a force within this biosocial organism and within its social components that tends to preserve unity.

> "The Principle of Unification —Motivation theory is incomplete without recognition that the prime need of an organism is to maintain its mental organization as a unified whole. The object of integrative forces in the organism is to preserve unity, particularly on the highest psychic levels. All other needs may be conceived as subsidiary to this primary motive. As with the concepts of mind or personality, unification cannot be observed or measured objectively but must be inferred from the patterns of organization and behavior."[2]

THEORY OF SELF-CONSISTENCY

The self-consistency of the individual can be related to self-consistency of the hospital, using the theory that the hospital is a living organism made up of human beings. Part of the quantum theory can be used in our concept of the hospital. Instead of studying the specific action of a single individual, let us consider the simultaneous action of many individuals over long enough periods of time to enable us to integrate the facts. Today the administrator must evaluate and experiment with mass phenomena. We, therefore, set forth the hypothesis that:

The theory of self-consistency as applied to a single individual applies to a group of individuals working together because of common need and by common consent in a hospital.

The theory of self-consistency is as follows:

> "The characteristics of a person on the highest levels of integration are determined by his way of life. The individual organization of ideas and attitudes which are acquired through experience and change control the highest intellectual functions. The essence of this organization of ideas and attitudes is self-consistency. An effective person can only go in one direction at a time or believe one thing at a time. Inconsistency or ambivalence results in disunity and paralysis of action. Behavior expresses the effort to be consistent and unified in organization and action. Ideas which are consistent with past experience tend to be assimilated. Those which are inconsistent

tend to be rejected. If an inconsistent attitude presents itself with sufficient urgency, it may force reorganization of pre-existing attitudes in order to eliminate inconsistency and regain unity."[3]

To apply this theory of self-consistency to the hospital organism, another part of the quantum concept must be used—*the dynamics of causality which run from the parts (components) to the whole.* We have said that the brain of this biosocial organism is the composite brain of the leaders of its components; then the leaders are capable, to some degree, of defining collectively the nature of the totality of the hospital. To maintain the hospital organization against external pressures, it is vitally important to determine the dynamic pattern of organization in each component group with particular reference to the ideas and attitudes that are its element of philosophy. In other words, we are saying once more that we need a unified philosophy which is a composite of all of the philosophies of all of the component groups.

Where, in this biosocial organism, is the heart? The heart of the hospital lies in the art of healing. I mean "the skillful and creative dispensing of any type of relief to the sick of body or heart, by physicians, nurses, and administrators. Like all the arts, it can be measured only in terms of the inspiration which it evokes . . . A sounder and more permanent foundation is built by the exhibition of genuine interest and by an obvious desire to be helpful. These qualities and the loyal concern they imply are basic necessities of the art of healing . . . Foremost among these are sympathy, of which many are capable, and compassion, a far rarer quality. For sympathy is given, hence may be simulated, may unconvincingly arise from a sterile heart; compassion is felt, and its depth and integrity establish a mood that calms and reassures almost wordlessly but with full conviction . . . The genuinely talented healer can understand the personality and environment of his patient. A combination of hearsay, questioning, and intuition can develop a remarkably complete picture of an individual, his temperament, the stresses of his life, his strengths and his weaknesses. Advise so guided may be of such value that the patient's life is happily altered while nature is curing the ailment that led him to seek help. For those whom nature cannot cure understanding and compassion offer a measure of peace to the troubled heart. These gifts that the healer may bring . . ."[4]

THEORETICAL ADMINISTRATION

"Theoretical hospital administration," in simple words, is a thoughtful and studious approach to our administrative job and the best way to do it. We should point out here, however, that it is not something that can be engaged in by amateurs or the untrained. We must have acquired specific knowledge, intensive training, and sufficient practice in hospital administration to administer a hospital with at least a passing grade. The hospital's special make-up calls for a person who combines in himself something of the insight of the skilled journalist, clinical psychologist, educator, artist, and statesman. We may, if we have the natural ability, apply common sense to facts based on reality, increase our power and capacity of thinking constructively about ourselves and our hospital, and be more able to judge wisely its many complex problems.

We are dealing with a biosocial organism, and with principles that include intangibles which are difficult to measure in linear terms or mathematical formulae. Here is where "theoretical hospital administration" finds one of its most important tools—the use of common sense. In addition, a sense of reality and self-consistency are desirable attributes. Common sense includes sound perception and reasoning, correct judgment of what is valid, practical, prudent and reasonable, a realization or discernment of values, and a sense of direction. This sense not only must apply to facts, persons, and objects but also must include a moral perception and appreciation. We are fortunate if we also have a sense of beauty and humor. As we have pointed out, individual ability plays a great role and often includes an instinctive perception or intuition which brings an acuteness in mastering administration. This individual attribute is often seen in musicians, artists, and physicians. It cannot be taught. It can be sharpened through teaching, application and practice.

It is hoped that common sense includes wisdom, a kind of common sense and judgment far above the average. Common sense can be described as the complement of intuition and conviction with sound good judgment concerning problems of truth and behavior. It is essential in making a decision, particularly when there is a conflict between hypothesis and reality or between two department heads. The use of common sense may be used to describe and understand the more complex psychological phenomena in a hospital that cannot be observed and measured directly but must be inferred rationally. The necessity for common sense becomes greater when attempting to deal with larger units of behavior of personnel functions in the hospital.

Scientific hospital administration, like other disciplines, can be established only by experimental means, by direct and rigorous application of reasoning to the facts furnished us by observation and experiment. Therefore, our theory requires in addition to observations, experiment. We do not in this paper outline experiments, but only bring to your attention some of the basic principles of experimentation. We quote from Claude Bernard:

"Gaining experience and relying on observation is different from making experiments and then making observations. In the philosophic sense, observation shows, and experiment teaches.

"To be worthy of the name an experimenter must be at once a theorist and a practioner. We cannot separate two things: the head and hand. An able hand without a head to direct it, is a blind tool; the head is powerless without its executive hand."[5]

What we say now is not said with the idea of discouraging students of hospital administration or the young administrator, but rather with the idea of stimulating him to "theoretical hospital administration." What we need in

(Continued on page 122)

THE medication nurse, making rounds with the medicine dispensing cart, prepares an injection.

An intensive care unit can become the center and heart of a medical-surgical area, according to the author. She discusses the planning, staffing and equipping of a 41-bed intensive care unit and also notes the reactions of the medical staff, nurses and patients.

THIS 41-BED INTENSIVE CARE UNIT IS THE HEART OF MEDICAL-SURGICAL CARE

by MRS. MARY T. ANCKER, R.N.

THE 41-BED intensive care section of the Lower Bucks County Hospital constitutes 39 per cent of all medical-surgical beds in the hospital. One-quarter of all patients in the hospital are in this special care wing. Since intensive

Mrs. Mary T. Ancker, R.N., is administrator, Lower Bucks County Hospital, Bristol, Pa. Mr. Carl Reeve, director of community relations, Lower Bucks County Hospital, assisted in preparing the material.

SOME of the equipment on hand for instant use in the intensive care unit includes (1) tracheotomy tray; (2) thoracentesis tray; (3) venous section tray; (4) catheterization tray; (5) gastric analysis tray; (6) culture tubes; (7) nebulizer-oxygen; (8) sealed drainage; (9) McKesson suction; and (10) pneophore machine.

Three months' survey of diagnosis, number, and average length of stay of patients in intensive care wing.

	OCT. (patients)	NOV. (patients)	DEC. (patients)	AVE. STAY (days)
G.I. Bleeders	2	8	6	19
Diabetics	4	2	4	19
Subtotal Gastrectomies	1	1	1	12
Cholecystectomies	10	4	7	16
Laminectomies	4	2	1	8
Asthma, Pneumonia, Bronchitis	9	8	6	15
Multiple Frac. & Gun Shot Wound	11	12	14	38
Heart Disease				
Cerebral Vascular Accident	8	1	3	22
Arteriosclerotic Heart Disease	1	1		14
Pericarditis	1	1		12
Acute Myocardial Infarction	5	2	6	32
Chest Pain	1	1	1	18
Coronaries	21	14	11	21
Congestive Heart Failure	2	4	4	48
Dyspnea Tachycardia	2			10
Cataracts	1	1		15
Appendectomy	1	6	1	5
Renal Calculi	1	3	1	6
Thyroidectomy	1	2		5
Herniated Disc	1	3	2	33
Urinary Retention	2	1		9
Intestinal Obstruction	3	4	4	28
Dehydration	1	1		17
Infectious Hepatitis	1	2		11
Acute Neuritis	1			2
Ileitis	1			11
Prostate Hypertrophy	1	1		11
Pleural Effusion	1			13
Osteo of Jaw	1	1		5
Hydro Uretus	1			3
Perforated Ulcer	1		1	7
Pancreatitis	6		1	37
Cellulitis	1			15
Acute Hemorrhoidal Prolapse	1			9
Brain Tumor	1	1	1	12
Radical Mastectomy	1			11
Malnutrition	1			3
Suprapubic Prostatectomy	1		4	11
Subarachnoid Hemorrhage	1	1		30
Herniorrhaphy	1	2		12
Vagotomy	1			9
Fecal Impaction	1			1
Exploratory Common Duct	1	1		16
Acute Sciatica	2			7
Concussion (poss.)	1			3
Brain Lesion	1	1		62
Peripheral Vascular Disease	1	2	1	28
Acute Tendonitis	1			33
Septicemia	1			9
Nephrosis	1	2	1	15
Attempted Suicides, Psychotics		3	1	4
Lupus	1			6
Ulceration of Leg and Complications	1			154
General Abdominal Surgery	1	2	1	11
	129	101	83	983

October—129 patients; November—104 patients; December—83 patients; Total 316 patients for 3 months.

Death Rate 7 per cent (7 each month)

Medical Cases—171—Surgical Cases—145

(Note—The figures of number of patients should be averaged for the three months. The survey took the number of patients in the intensive care wing on October 1st and added all new admissions and transfers into I.C. in October, November and December.

care has been inaugurated, it has become the center and heart of the medical-surgical areas, and is, we believe, the largest such unit in the community hospital field.

The Lower Bucks County Hospital's intensive care program, planned in September 1957 and put into operation in February 1958, had handled 975 patients in the 7 months from Feb. 1, 1958, to Dec. 31, 1958.

The size of this department indicates that the intensive care wing is not a recovery wing with only a few beds. There is a recovery room in the hospital which serves the definite purpose of immediate postoperative care. In fact, according to a three month survey conducted in the hospital, intensive care cases are in the main medical rather than surgical. This contrasts to many intensive care wings where the majority of cases are surgical and the number of beds in the special unit are small. There were 171 medical cases and 145 surgical cases in I.C. in the last three months of 1958.

The low mortality rate of 10 per cent for an 11-month period is encouraging, considering the number of critically ill cared for in the I.C. wing. Some intensive care units have reported mortality rates as high as 24 per cent. Although the hospital does not usually admit long-term cases that could go to a nursing home, it does take patients who require hospitalization, regardless of the critical or terminal nature of their illness. Our census for the fiscal year ending May 31, 1958, showed that the death rate for adults in the hospital (including pediatrics) was 1.54 per cent. A three-month survey showed that the average deaths in the special care department for the three months ending Dec. 31, 1958, totaled an average of seven per month or a percentage of about 7 per cent.

Lower Bucks County Hospital is a 150-bed, short-term general hospital in a rapidly growing area located at Bristol, Pa., in the heart of the Delaware Valley industrial center. Overcrowding has been a problem almost from the beginning of our existence. The population of Lower Bucks County has increased by 300 per cent since 1951, and is still rising. The hos-

pital recently celebrated its fourth anniversary.

The hospital was fully accredited 14 months after opening. In November 1958, ground was broken for the new $767,983 expansion program. Sixty-five beds, or 43 per cent of the hospital's capacity and a new outpatient and clinic wing will be added. Forty-six of the 65 new beds will constitute a new fourth floor especially designed and constructed as an intensive care wing, scheduled for completion in November 1959. This wing will have innovations based on our experiences in intensive care for the past year.

This added capacity will, we believe, allow for a much more efficient intensive care wing and will relieve the shortage of beds. We anticipate however, that there will be 100 per cent occupancy from the very beginning of the new section.

The five months of thorough planning before putting intensive care into effect included meetings of the administrator with the nursing director and medical-surgical supervisor, the medical staff and the admissions officer. These meetings were followed by individual conferences with doctors and the nursing staff, in order to get full cooperation and prevent objections or misconceptions regarding the plan. On Jan. 24, 1958, a public announcement was made by the hospital administration of the inauguration of the intensive care program. This announcement explained the type of patient who would be cared for in the intensive care wing, the procedures to be followed on the unit and the special equipment and kind of nursing care available there. The announcement also indicated the methods of admissions and transfers.

ADMISSIONS

The type of cases usually treated in the intensive care section is as follows: coronary cases, G.I. hemorrhages, diabetes, fractures (vertebral), cerebral-vascular accidents, subtotal gastrectomies, cholecystectomies, craniotomies, limb amputations, laminectomies, suprapubic prostatectomies and extensive burns.

A representative of the admissions office, the nursing supervisor and the head nurse meet daily and settle most of the day-to-day problems. If a question cannot be settled, it is referred to the admissions committee, composed of the administrator, a representative of the medical staff, the director of nursing and the admissions officer representative. The doctor is consulted before a patient is typed for admission. But the final assignment rests with the above committee, and is determined by nursing care requirements, regardless of the doctor's request. This procedure must be accepted by the medical staff and enforced; otherwise the special care project is doomed to failure from the beginning.

Whenever possible the patient being admitted to intensive care is told the purpose of intensive care and is given a mimeographed instruction sheet which states, "It is the policy of the hospital to designate the nursing area to which you will be admitted. Patients requiring skilled nursing care, continuous treatment, or whose activities must be rigidly controlled will be admitted to the intensive care unit regardless of preference, where special equipment, drugs and nursing personnel will be concentrated. This extra service, at no additional expense, will greatly benefit the patient who needs it.

"Regulations for the intensive care unit are as follows: All valuables and clothing must be taken home at time of admission. Visiting must be kept at a minimum and confined to immediate relatives. Phones will not be available in this area. All calls for patient information will be handled by the auxiliary to permit the patients to receive full benefit of care and rest. Television will be permitted only by approval of the head nurse, and the physician.

"Transfer from the intensive care unit to the other areas will be effected when the patient no longer requires this extra attention."

When the patient is improved sufficiently to be transferred from the intensive care unit to the moderate care wing, the head nurse evaluates the nursing care needs with the approval of the physician, and effects the patient's transfer. Regardless of diagnosis, when the patient is able to help himself, he is transferred to an area staffed with a smaller number of professional personnel, but sufficient to care for him. The head nurse explains to the patient the reasons for transfer, contacts the admissions office for area and room number, and notifies the area of the transfer. The nurse takes the patient in a wheel chair to his new area, sends all transfer slips to departments involved and takes all information concerning the patient to the new area.

When the patient is transferred to the moderate care wing, the nursing clerk or messenger in intensive care sends the addressograph plate to the admissions office with a penciled notation of the new bed assignment. A new plate is then made. A notation of the new assignment is left in the doctor's mailbox, notifying him of the patient's new bed location.

The medical-surgical supervisor and a number of patients have pointed out that the convalescent patients transferred from intensive care are satisfied with the moderate care wing. They get more companionship, they can watch television, play cards and read. Their sleep is undisturbed by seriously ill patients.

As soon as the new I.C. wing is completed, we plan to make a greater differentiation in the moderate care wing by having separate wings for those ambulatory patients who require minimal care and can largely take care of themselves. In other words, the moderate and minimal patients will be put into two separate areas. When more beds are available, attention can be given to this logical step.

DUTIES OF HEAD NURSE

The duties and functions of the head nurse in I.C. are clearly defined by the nursing department. It is she who:

1. Delegates responsibility for patient care to assistant head nurse or team leader.
2. Plans time and work sheets.
3. Attends reading of reports.
4. Supervises over-all area.
5. Makes rounds with doctors.
6. Checks equipment.
7. Supervises ordering of supplies.
8. Evaluates personnel and makes

changes as needed. Writes evaluation records of personnel.

9. Assists team leader in planning assignments.
10. Makes contact with team members through team leader.
11. Keeps close contact with social service director.
12. Stresses value of communication through team leader to all personnel.
13. Assigns auxiliary aides.
14. Instructs new members of team or private duty nurses in hospital policies.
15. Meets with supervisors and department heads when problems arise.

The duties and functions of the team leader in I.C. are to:

1. Check narcotics with on-coming nurse.
2. Receive report from off-going shift.
3. Visit each patient previous to assignment.
4. Assign personnel as required.
5. Review visible card file orders against charts and check medicine and treatment cards.
6. Transpose orders from chart to card file, make out medicine cards, etc.
7. Order required equipment from central supply room.
8. Check all patients going to and returning from the operating room.
9. Make rounds with doctors when possible.
10. Visit all new admissions and delegate nursing personnel as required.
11. Stress value of communications through team leader to head nurse.
12. Assist head nurse in carrying out policies of hospital.
13. Relieve head nurse on her days off.
14. Supervise nursing care rendered on team.

NURSING CARE IN I.C.

The intensive care principle is a natural accompaniment of the team system, which was first advocated because the shortage of trained nurses made necessary the improvement of nursing methods.

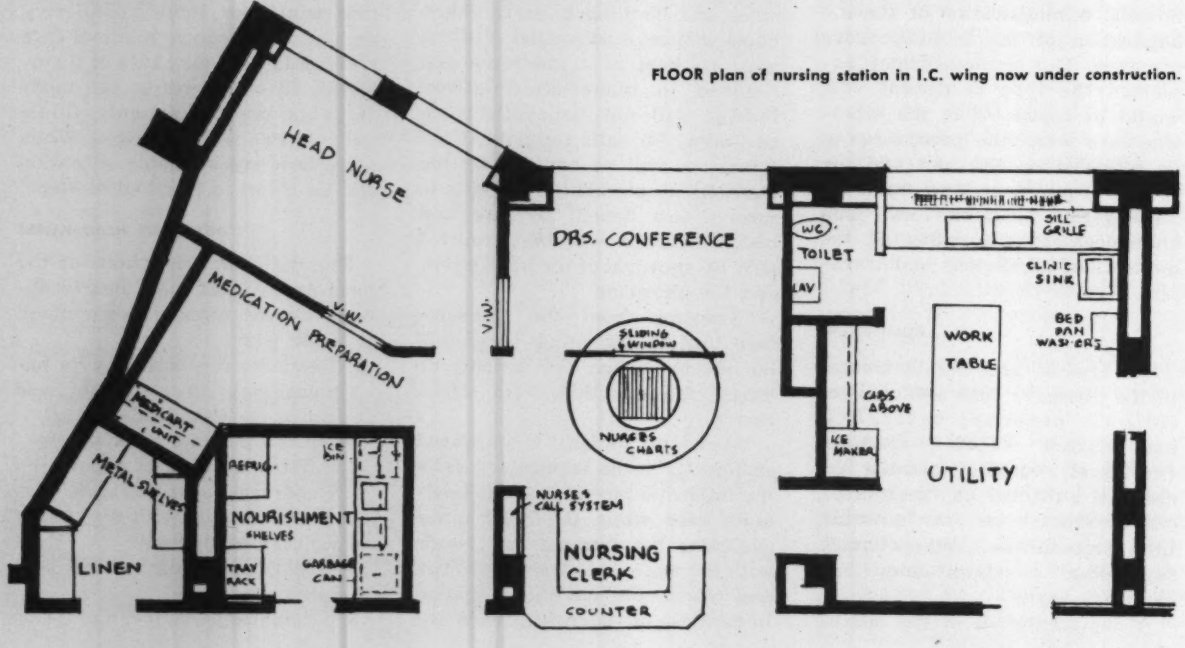
The concentration of nursing care in our I.C. wings is evident in view of the fact that nearly six hours of nursing care per patient is given in our intensive care unit, as compared to approximately two hours of nursing care per patient in our other units.

When the intensive care unit was set up on Feb. 1, 1958, a reassignment of personnel from the whole medical and surgical department was made, with the number of personnel nearly doubled on all shifts of the intensive care wing. This change was made after many conferences were held with the head nurses, the medical surgical supervisor, and the director of nursing. All personnel affected were then consulted, before the change, so that a minimum of resistence to the plan would be encountered.

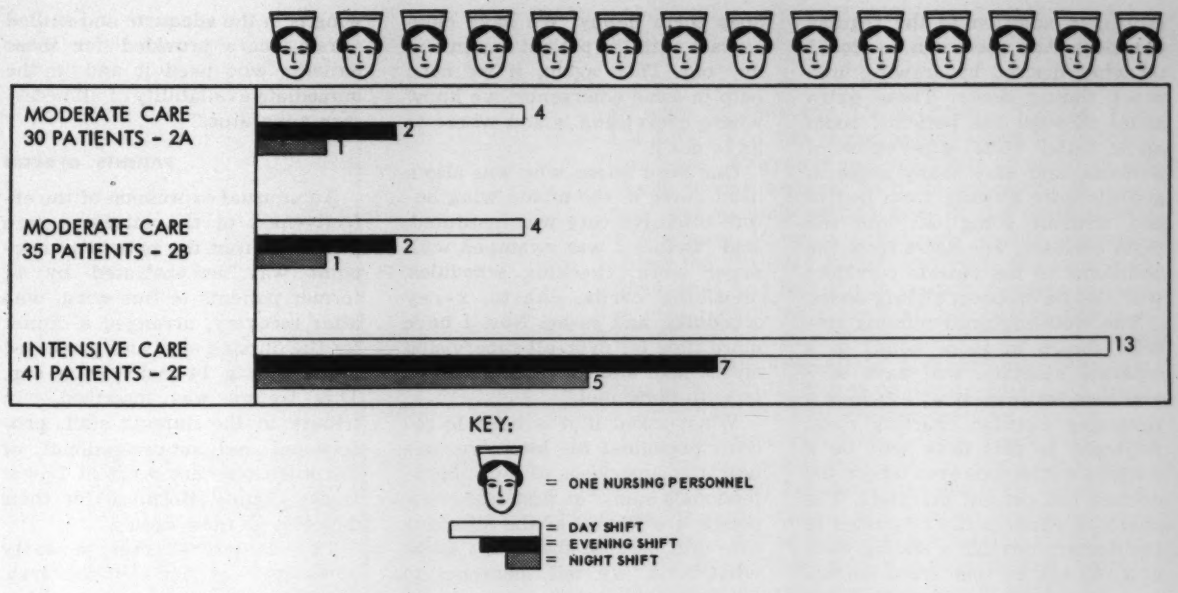
Even with all the conferences, there was at first some dissatisfaction and lowering of morale, because the nurses were not familiar with the system of concentrating the seriously ill in one unit and removing them to another area when they were on the way to convalescence. In the first few weeks, however, the nursing staff had a better understanding, especially after they had seen the recovery of a number of seriously ill patients. The nurses were asked to volunteer for I.C. and none was forced to go into it against her will.

On Feb. 1, 1958, 46 patients were shifted into the new I.C. unit. There are 25 members of the nursing staff on the three shifts in I.C. taking care of 41 patients. The nursing staff includes 12 registered nurses and 13 subprofessionals. In addition, there is one supervisor and a nursing clerk on each shift.

The nurses are all working on the team plan with the exception of a medication nurse, who is responsible for administering all medication to the patients. The rest of the nursing personnel is divided into two teams on each



FLOOR plan of nursing station in I.C. wing now under construction.



GRAPH shows nurse-patient ratio

shift; each team is composed of a professional nurse and one or more subprofessional workers to assist her in caring for a group of patients. To provide less adjustment of patients to personnel, and more incentive to personnel to improve the quality of their care, an adequate number of permanent general nursing staff is assigned on a weekly basis to the unit so that there is a minimum need for supplementing the daily staff with relief personnel.

The total nursing personnel in a 24-hour period for intensive care and moderate care is summarized as follows:

Total nursing personnel in intensive care 25
(for 41 Beds)

Total nursing personnel for moderate care 14
(for 65 Beds)

Number of patients per nurse in intensive care 1.64

Number of patients per nurse in moderate care 4.64

EQUIPMENT

The intensive care wing now being built will have more room and will be a considerable improvement over present facilities. However, the present intensive care wing, though overcrowded and with space at a premium, is well equipped.

Oxygen and suction is piped into the walls with an outlet at the head of each bed.

The following is the equipment and drugs on hand in the intensive care wing for instant use (this equipment is not kept in any other patient area):

1. Tracheotomy tray
2. Venous cut-down
3. Oxygen tents
4. Oxygen face mask
5. Oxygen humidifier and gauge
6. Aspirating catheters
7. Wall suction
8. Oxygen nasal catheters
9. Resusitators
10. I.V. tray
11. (3) 1000-c.c. 5 per cent dextrose in water
12. (3) 1000-c.c. 5 per cent dextrose in saline
13. Tourniquets (for rotating procedure)
14. 1000-c.c. distilled water for humidifiers
15. Sterile tubes for withdrawing blood
16. Various sizes polyetheline tubing (sterile)
17. 50-c.c. syringes
18. 6 blood pressure apparatus
19. Adult walker
20. 6 portable I.V. standards
21. 2 Stryker frames

The following equipment is kept on all medical-surgical areas, including intensive care. One physical examination tray including:

1. Ophthalmoscope otoscope
2. Percussion hammer
3. Flashlight
4. Tongue depressors
5. Measuring tapes
6. Sterile applicators
7. Sterile slides
8. Sterile culture tubes
9. Blood pressure apparatus
10. Stethoscope
11. Safety pins

Also kept in all areas, including intensive care, are: medicine dispensing, emergency stimulant kits, stock drug kit, stretchers, wheel chairs and dressing carts.

PROSPECTIVE IMPROVEMENTS

In the new intensive care wing under construction, one of the marked improvements will be a quiet room for noisy or delirious patients. At present, due to overcrowding, makeshift quiet rooms have had to be used, such as the recovery room, or a private room made available by transfer of patients. In the new wing, there will also be two isolation rooms fully equipped with toilet, lavatory, cleaning facilities and workrooms with trays, etc.

One of the new departures in hospital construction which we believe is being inaugurated by our hospital will be aisles going through the center of the bed-

rooms, in addition to the regular corridors. Any room can be closed off when desired by drawing fireproof sliding doors. These extra aisles through the patients' room allow better visual supervision of patients, and save many steps in getting more quickly from bed to bed without going out into the main corridor. The doors from the bedrooms to the outside corridors will also be fireproof sliding doors.

The well-equipped nursing station, shown in more detail in a separate diagram, will have several new features. It will include a revolving circular charting desk. Adjacent to this desk will be a doctor's conference area where the doctors can consult privately. The charts of patients can be passed to the doctors through a sliding window. As can be seen from the accompanying diagram, around the nursing station will be concentrated the nursing supervisor's office, a room for medication preparation, and a utility room with an ice-making machine. Another feature in this area will be the well-equipped nourishment room. Across the corridor from this nursing center will be subnursing station where the nurses can write up their charts.

There will be more storage rooms. All the latest equipment and drugs will be available. The solarium will be used as a waiting room for families of seriously ill patients. Three utility rooms with bathroom facilities will be on the floor. There will be a number of bedpan flushers and one sink for every four patients. Oxygen pipelines and suction pipelines of course are built into the wall over each bed.

NURSING OPINION

The reaction of the nurses to the intensive care system seems to be unanimously favorable.

One of the practical nurses who has worked in the moderate care as well as intensive care said, "Where I worked before there was a mixed group of patients. Some were seriously ill and some were ambulatory. Now many are seriously ill and all patients require constant care. We have time to give them good care which was not the case before. We can even cater to some of their whims and keep them happy. We have close contact with the patient day in and day out. Then again, if we need help in some emergency, we know where everything is and where to go to get it."

One head nurse, who was also a head nurse in the mixed wing before intensive care was instituted, said "Before I was swamped with paper work, checking schedules, medicine cards, charts, x-ray schedules, and so on. Now I have more time for over-all supervision on the floor and for working closely with personnel."

When asked if it is hard to recruit personnel for intensive care unit, the supervisor of the subprofessionals said, "at first some new people are fearful of the intensive care unit because they don't know what it is. We tell them not to listen to rumors but to try it out. After they have been in the area a few days they are happy to be working there."

PHYSICIANS' OPINION

The director of the department of internal medicine said, "From the medical doctor's viewpoint, the main advantage of I.C. is that intensive nursing care is available when necessary. With patients in a condition where close observation is necessary, namely hemorrhage, acute cardiac disease, and coma, adequate nursing care is essential and is readily available now in I.C. Of course private duty nurses are still better and are not precluded by the intensive care. But it is not always practical for financial reasons for patients to have private nurses for long periods. The setting up of the intensive care in one area means the maximum benefit from nursing care available."

The hospital's chief surgeon said that the nurses in I.C. are directing their attention to the problems of the seriously ill and are versed in the needs of postoperative care and the use of the needed apparatus and equipment. Therefore, there is not the risk of accidents occuring, such as blocked up tubes, etc. "Postoperative accidents due to lack of familiarity with equipment are avoided," he said. "As far as surgical cases are concerned," he said, "the big difference between the I.C. wing and the moderate wing is in the adequate and skilled nursing care provided for those patients who need it and in the immediate availability of all necessary apparatus."

PATIENTS' OPINION

An unusual expression of the effectiveness of the intensive care principle from the patient's viewpoint was demonstrated by 11 former patients in this wing, who after recovery, arranged a dinner for the nursing staff and presented them with a 14-inch loving cup. This trophy was inscribed, "In tribute to the nursing staff, professional and subprofessional, of the intensive care wing at Lower Bucks County Hospital, for their devotion to their duties."

The *Courier-Times*, a daily newspaper in the Bristol area, noted, "If a similar testimonial has happened elsewhere, we have never heard of it."

One patient, a small businessman, was in the hospital several months, with the complications arising out of a fractured leg, and a subsequent heart attack. He particularly praised the practical nurses for their attentive care and efficiency. His morale was so good that after he had been in the hospital for some weeks, he asked that a patient who needed to have his spirits raised be put in this semiprivate room, so that he could help cheer him up.

A female patient who was recently in the hospital, and was also a patient before I.C. was set up, said that the difference in nursing care is "amazing." On her latest visit she was in I.C. and then transferred to the moderate care section. She said, "The intensive care and moderate care wings are such a logical way of caring for the sick that I don't understand why hospitals have been so slow in using this system."

The burgess of a town in the area, in I.C. for a cardiac condition paid a high tribute: "When my daughter was graduated from nursing school I insisted that she try working in the Lower Bucks County Hospital, in the I.C. wing. She is glad she did. She is not only getting a real training in care of the seriously ill but also the satisfaction that comes from doing a good job in nursing." ■

THE HOSPITAL THAT PENNIES BUILT— *five years later*

by MRS. HELEN D. BEHNKE, R.N.

EARLY IN 1954 the TV program, "This Is Your Life", told the entire nation about the beloved "Dr. Kate" Newcomb and her years of effort to get enough money together to build a hospital in a remote and sparsely settled area in the north woods of Wisconsin. Various participants on the show described the "Penny Parade", started in the local high school, that had brought in enough pennies to start the construction of a hospital, but not to finish it. The idea so intrigued thousands of TV viewers that they sent $102,000—all in pennies—into the little town of Woodruff, Wisconsin. It was enough to bring to completion the half-finished building.

Lakeland Memorial Hospital has fared very well since that exciting opening day in April, 1954. Now, five years later, Lakeland has not only served the needs of both whites and Indians scattered over hundreds of square miles—it has become a vital part of their lives. They give it a loyalty and support seldom experienced by large urban hospitals.

The outstanding feature of Lakeland is that, while all is in miniature, it is a complete general hospital in every sense of the word. The pediatric unit has two cribs and a junior bed. The obstetrics unit consists of four beds, six cribs, two incubators and a modern delivery room where 147 babies were born in 1957. The emergency room not only takes care of dozens of accident cases each month, but it is also used by the outpatient department for such treatments as diathermy and whirlpool baths. Laboratory, x-ray and central supply departments are fully adequate. The case load—about 60 per cent of capacity the year round and 100 per cent during the five summer months—provide the staff with a variety of cases and experience, despite the fact that the hospital has only 24 beds. The hospital is not equipped to do neurosurgery, brain surgery, or open heart or chest surgery, but it does just about everything else.

Mrs. Helen D. Behnke, R.N., is assistant editor, American Journal of Nursing.

Since the area in which the hospital is located abounds in lakes and the woods are full of game, a large percentage of the accidents treated are the result of injuries to sportsmen. These are usually due to the mishandling of fish hooks, water skis and boats. Winter accidents are frequent, too, ranging from hunters' gunshot wounds to woodcutters' axe and saw injuries, to severe burns resulting from fires caused by the crude heating devices the loggers use in their cabins.

Of course, the income from patients is not enough to pay the operating costs of the hospital. The fiscal year 1957-1958 showed a deficit of $5,350.76. But, as happens every year, donations from local summer residents and other friends of the hospital erased that deficit. In fact, when the books were closed they showed a surplus of $1,030.86.

DEDICATED COMMUNITY

From the very first day, people of the surrounding communities assumed the responsibility of keeping the hospital solvent. Woodruff, with a population of only 800, has contributed $5000 during the past few years. Hazelhurst and Lake Tomahawk, two tiny towns seven miles away, gave $500 and $600 respectively. Arbor Vitae (pop. 750) contributed $7000. Other towns have voluntarily taxed themselves in order to carry their share of the upkeep.

But money isn't all these people give. They keep informed about the hospital's needs and take a tangible part in planning its future. Recently, when funds were not at hand for the installation of an emergency water system, the cost—well over $1500—was borne by two Lakeland area residents. Another, realizing that the hospital will have to expand soon, contributed four lots of land adjoining the original site. Still another resident gave land sufficient to square off the boundry lines. And so it goes. Whenever there is a specific need, the people of the community meet that need.

Employees of the hospital are equally dedicated. Last summer the nurses decided to replace the outmoded operating table that had been given when the hospital opened. They organized a campaign and raised more than $2200 to buy a modern operating table. There was some money left over, so it was put into a "kitty" with the expectation that there would soon be enough to provide a much-needed intercom system.

Only 10 full-time registered nurses are employed at Lakeland. Most of them are married and live in one of the neighboring villages. The hospital also employs 10 nurses' aides and 2 licensed practical nurses.

STAFF COMPETENCIES

The medical staff consists of a chief and four physicians who all live within commuting distance of the hospital. Three consultants live in Wausau, 72 miles away. They are specialists in radiology, pathology, and cardiology. The attending physician does a preliminary reading of x-ray films, but once a week all films are sent to Wausau for a detailed reading. In an emergency, of course, someone makes a special trip to Wausau with the films. Biopsies may be done by the consulting physician, or they may be done in the state laboratory in Madison. But the Lakeland technician does all the blood and other routine laboratory examinations at the hospital.

Lack of narrow specialization accounts for much of the informality and the friendly spirit that exists among the staff. Staff members help each other out whenever the need arises. Everybody eats at one long dining table. The R.N. is held in high regard by the other employees and by the townspeople. The letters "R.N." carry affection as well as prestige in the community. Everyone knows that these women, many of whom have home responsibilities and help their families operate resorts and other businesses work just because they like the sort of nursing done at Lakeland, are providing a life-giving and life-saving service to thousands of people who would otherwise have to travel many miles to another hospital or go without treatment. Dr. Kate is no longer living, but her spirit will never be lost by those at Lakeland Memorial Hospital.

Thus, the little hospital that pennies built is filling a long-felt need. The time will come when it will be necessary to expand. The land has already been donated, and the friends of Lakeland Memorial Hospital are confident that money will be available for the addition when it is needed. The almost fantastic results of a television show and a "Penny Parade" have given them a great deal of faith. ■

FIVE MAXIMS OF DECISION-MAKING

1. Decision-making is not an event, but a process; it goes on all the time. Large decisions are usually the inevitable piling-up of small ones.

2. Choice is a form of transaction between the individual and his total (physical, social, intellectual) environment. The chooser and the chosen are always mixed up in the equation.

3. All decisions are compounded of the rational or logical, and the nonlogical.

4. A decision is always made on insufficient evidence—and is thus always bold and audacious to a certain extent.

5. Any decision is three-dimensional in time, consisting of memory, present perception, and the anticipated future.

—ROBERT N. WILSON, PH.D. ***speaking at the second Congress on Administration of the American College of Hospital Administrators, Feb. 6, Chicago.*** ■

Six-way cooperation fights 'staph' in Cincinnati

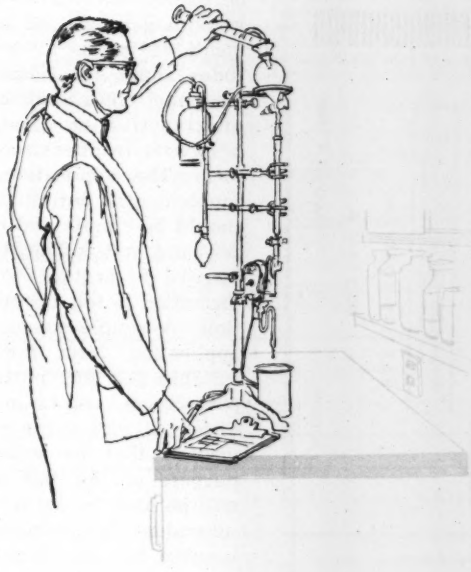
by JERRY N. RANSOHOFF

SIX-WAY COOPERATION has led to a staphyloccocal control program in Cincinnati and the surrounding area. The key service in the area-wide control program—the Cincinnati Staphyloccocus Phage Typing Laboratory—was established with the help of the United States Public Health Service, the Ohio Health Department, the Hamilton County and Cincinnati Health Department's private industry and the Greater Cincinnati Hospital Council.

The movement to establish the laboratory started after an 18-month study showed that infections occurred primarily in newborn nurseries and maternity wards. Immediate steps were taken to limit exposure and seek out and control the infection.

Initial steps to establish a phage typing laboratory were taken by local hospital and health authorities in January 1958. Next, the Ohio Health Department offered to pay the salary of a bacteriologist if the Cincinnati area could provide the rest of the facilities.

It was believed that the laboratory should not be located in any one hospital, but should be in a separate nonhospital laboratory building. Through the help of the United States Public Health Service, space was made available in the laboratory building of the Robert A. Taft Sanitary Engineering Center. Basic facilities were to be provided by the PHS. Meanwhile, the hospital council was working closely with the health commissioner of Cincinnati, setting up a system for preparing and assembling cultures, making reports and taking care of other expenses.



A Cincinnati insurance company agreed to provide an assistant for the bacteriologist for a three-month period.

The bacteriologist spent a month learning the techniques of phage typing at the Ohio Health Department laboratory at Ohio State University. The phage typing laboratory opened on May 12, the first day of National Hospital Week.

In the first month of operation, 220 cultures were typed. Since then the work load has increased, as the hospitals of Cincinnati area are now undertaking routine and periodic cultures of personnel. After a year of operation, the Ohio Health Department added a nurse and a secretary to the Cincinnati project. The nurse, who holds an MPH degree, conducts epidemiological studies of all reported resistant strains of staph, particularly those showing the 80/81-ADP pattern. The secretary prepares reports for hospitals, doctors and the interhospital infections committee. The laboratory currently is processing about 600 clinical and 50 to 100 survey cultures per month.

Under the established procedure, cultures are submitted on slants of salt agar in small vials. The agar slants are prepared by the laboratories of individual hospitals, or in some instances by the Cincinnati Health Department laboratory. These vials are carefully labeled and are submitted for phage typing along with a blank furnished by the staphylococcus laboratory.

The laboratory not only serves the hospitals in the Cincinnati area, southwesthern Ohio, southeastern Indiana and two counties in northern Kentucky, but also has answered the needs of private physicians and of public health nurses in typing positive staph cultures.

The operating expenses of the laboratory are reported to the hospital council, which has developed a formula for pro-rata payments. The amount each hospital, the county and each individual user owes for the current period is submitted to the Cincinnati Health Department. Bills are rendered by the city treasurer and payment is made to him for laboratory expenses. In this way, the city of Cincinnati more or less advances

(Continued on page 122)

Jerry N. Ransohoff is executive secretary, Greater Cincinnati Hospital Council, Cincinnati.

THE ROLE OF THE employee as an ambassador of good will for his organization has been well established in the hospital field and elsewhere. Obviously, then, the better informed and happier he is, the better ambassador the employee will make.

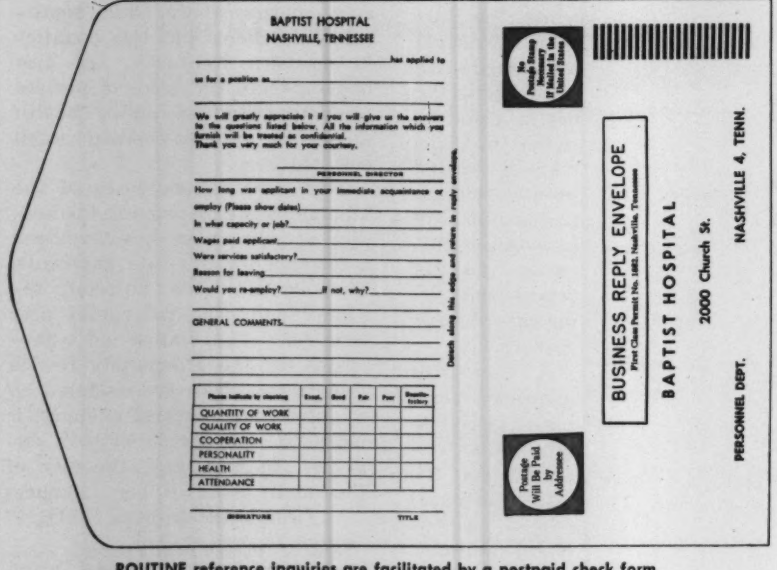
Employee information and job satisfaction stems to a large degree, from the initial orientation period. How this program is directed may spell the difference between good relations and bad. The employee may be expected to find his way around and figure things out "as best he can", or orientation may be the responsibility of a busy department head who may not be qualified for this function. Some organizations have an elaborate and expensive program conducted by highly skilled and especially trained personnel using expensive equipment and techniques.

Employee orientation programs vary widely, but they should all concentrate on building good will, and interest in the hospital, according to the author. He discusses one hospital's program that includes two unusual ideas—a visual color slide tour of the hospital and a perpetual follow-up recording device.

Orientation is essentially a matter of communication. There must be some means of follow-up. The purpose of a hospital orientation program then is simply to get the worker off on the right foot, to help him have confidence in himself and the hospital, and to feel that the hospital is interested in him and will treat him fairly. This paper will examine some of the factors to be considered, and briefly review how they are approached in one hospital of 335 beds, the Baptist Hospital, Nashville, Tenn.

Orientation begins with the first contact, which generally is the personnel office. Even before the individual is selected for employment, he begins to develop attitudes about the hospital. If the personnel office is difficult to find, unattractive or uncomfortable, negative impressions begin to form. The application form and supplemental information sheets should be simple and easy to understand and sufficiently comprehensive to acquire whatever information is felt necessary at this time. A simple screening type of application form may be most suitable for this purpose. If the prospective employee is to be tested in any manner, it is important that he understand the purpose of the test and how it will be used in the selection of an individual for employment. This hospital has used the free service

Robert P. Brueck is assistant administrator, Baptist Hospital, Nashville, Tennessee.


BAPTIST HOSPITAL
NASHVILLE, TENNESSEE

_____ has applied to us for a position as _____

We will greatly appreciate it if you will give us the answers to the questions listed below. All the information which you furnish will be treated as confidential.
Thank you very much for your courtesy.

_____ PERSONNEL DIRECTOR

How long was applicant in your immediate acquaintance or employ (Please show dates)_____
In what capacity or job?_____
Wages paid applicant_____
Were services satisfactory?_____
Reason for leaving_____
Would you re-employ?_____ If not, why?_____
GENERAL COMMENTS_____

Detach along this edge and return in reply envelope.

Please indicate by checking	Excel.	Good	Fair	Poor	Unsatisfactory
QUANTITY OF WORK					
QUALITY OF WORK					
COOPERATION					
PERSONALITY					
HEALTH					
ATTENDANCE					

SIGNATURE _____ TITLE _____

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY ENVELOPE
First Class Permit No. 1485, Nashville, Tennessee

BAPTIST HOSPITAL
2000 Church St.
NASHVILLE 4, TENN.
PERSONNEL DEPT.

Postage Will Be Paid by Addressee

ROUTINE reference inquiries are facilitated by a postpaid check form.

ORIENTATION: *a channel for good will*

by ROBERT P. BRUECK

of the state department of employment security in obtaining well validated screening and aptitude tests. These tests are useful as an aid to selection for certain categories, such as nursing aide and clerical classifications.

The initial interview should be brief, specific, firm, and sympathetic. If there appears to be no opportunity for employment this should be indicated in a manner as to leave no question. These then, are the first contacts and their importance should not be underestimated.

HIRING PROCESS

The next contact in the orientation procedure is normally the hiring process. This procedure involves interviews with the department head or supervisor concerned, or with the administrator or personnel director, or possibly with all these individuals. References are checked and the prospective employee should understand that a careful selection is going on in an effort to obtain the best qualified individual for the job available.

A simple postpaid check form may be used for making routine reference inquiries. This form is convenient for an employer to mark and return at no expense and results in a greater number of written references returned than would be expected if the reference individual were asked to write a letter. It is also easily and quickly handled by the personnel office.

After the individual has been selected for employment, other supplemental information sheets must be filled out, a personnel and payroll record completed, and any employee's questions answered. At this time a basic information sheet may be given the new employee. This sheet should include such basic information as department, job title, hours and time card number, salary, the next pay day, payroll deductions, hospitalization and life insurance available, and a message regarding safety. At this time a written invitation to attend the orientation session is given the new employee.

BAPTIST HOSPITAL
Nashville, Tennessee

INTRODUCTORY INFORMATION

Welcome to Baptist Hospital. You are beginning a three month introductory period to a great hospital and an outstanding team of men and women dedicated to serve the sick and injured. The information below will help you get started. You are required to attend an Introduction Meeting on _____ at 2:00 P.M. in room #124 in the School of Nursing Building to learn more about your hospital.

YOUR DEPARTMENT _____ YOUR JOB TITLE _____

YOUR HOURS _____ YOUR TIME CARD NUMBER _____

The Time Clock is located near the Emergency Room Entrance.

YOUR SALARY _____ PAY DAY IS EVERY OTHER FRIDAY. YOUR FIRST PAY DAY IS _____.

Pay deductions are made for withholding tax, social security, and hospitalization insurance. Do you want to take out hospitalization insurance with Baptist Hospital? You are covered by Workman's Compensation Insurance, have sick leave allowance, hospitalization employee discount allowance, five holidays, two weeks vacation, and you will receive a free life insurance policy after 6 months service. If you are injured on the job, inform your department head and go to the Emergency Room. The Emergency Room is on the first floor of the West Building. Remember it pays TO WORK SAFE.

Your Department Head will tell you about:

COURTESY	YOUR FELLOW WORKERS
THE FUNCTION OF THE DEPARTMENT	WHAT TO WEAR
WHERE TO EAT	WHERE TO PARK
TELEPHONE	MAIL
SMOKING	BULLETIN BOARDS
HOLIDAY ARRANGEMENTS	DISASTER PLAN ASSIGNMENTS
INTRODUCTION MEETING	

DO YOU HAVE ANY QUESTIONS?

NOTES: _____

BASIC information sheets help orient new employees to the hospital.

INDIVIDUAL ORIENTATION

The next step in employee orientation may well be the individual orientation. This is primarily a responsibility of the department head and is carried out prior to the group orientation session. The information should be kept simple, but any questions should be answered. The department head may cover such matters as: courtesy, introduction to fellow workers, the function of the department in general, what to wear, where to eat, where to park, use

of the telephone, mail, smoking, bulletin board, holiday arrangements, and disaster plan assignments.

A proven system to follow after this introductory period is the "buddy system"—assignment of the new employee to an experienced employee who will assist him in getting settled and acquainted with the department, surroundings and other personnel. Soon thereafter begins a training period, which may be formal or informal, depending to a great extent upon the amount of background and preparation the individual has had for his job. Many persons working in hospitals are already highly skilled and highly trained individuals who have been through considerable schooling. Others have had little or no schooling and training for their job. All of them will need to learn techniques peculiar to the institution. This, of course, is the responsibility of the individual department head and whatever experienced worker may be assigned to help.

The next phase of employee orientation may be the group orientation period. These group orientation programs may be held at varying frequencies, depending upon the size of the institution and the employee turnover. At Baptist Hospital group orientation sessions are held once a month. Personnel on all shifts are expected to attend these group orientation sessions and are so advised on their first day of employment.

GROUP ORIENTATION

The plan for these sessions is as follows:

1. *A brief introduction to the hospital, including its historical background.* This talk is short, and is intended only to set the stage with background information.

2. *Personnel policies.* This discussion is carried out with the aid of cards and a flannel board. These visual aids are used to place each topic and heading before the new employee while it is being discussed.

3. *Role of the hospital chaplain.* A talk by the hospital chaplain acquaints new personnel with the services he provides, how personnel can be of assistance to him, and how he may be of assistance to them.

4. *Refreshments.*

5. *Insurance program of the hospital.* The hospitalization insurance is discussed in detail. Workman's compensation requirements are explained and the group completes application cards for the group life insurance program, which is furnished by the hospital. Careful attention is given to all questions.

6. *Tour of the hospital.* This tour is made without the employees ever leaving their seats. A presentation is made in the form of color slides. These slides are prepared in four series. The first series shows some of the activities and the functions which the patient may see and participate in during his or her confinement in the hospital. The second series, pictures of each department in the hospital, is accompanied by a brief description of each and pertinent statistical information. The third series contains pictures of each of the buildings comprising the hospital. The location of different areas of the hospital is explained at this time. The fourth series of slides pictures key personnel in the hospital with whom the new employee should become acquainted.

7. *Safety and disaster planning.* A discussion of the safety program and the disaster plan is made with the assistance of a paper tape pull training aid. The group orientation session concludes with a question and answer period.

In this program an effort has been made to develop and use as many visual aids as possible. The development of this phase of the program is a continuing one. Aids being used at the present time are blackboard and chalk, flannel board, color slides, charts, and paper pulls. Informative booklets are given to the employee at this time. A book describing the insurance program and a safety manual prepared by the insurance carrier are distributed. (If they are available, it is desirable to distribute employee handbooks at this time.) The new employee also receives Blue Cross information and a small pocket fact information card of hospital information.

Following the orientation period, the employee is released to his department head. Several means are used to provide constant follow-up on each individual employee. At the end of the three-month introductory or probationary period, the new employee receives, at his home, a letter from the administrator welcoming him to permanent status on the hospital staff and reminding him of his obligations to the patient and the hospital. At the end of this period, an evaluation of the employee is made by the department head, and for some jobs, a raise in salary may be recommended.

EMPLOYEES' CONTRIBUTIONS

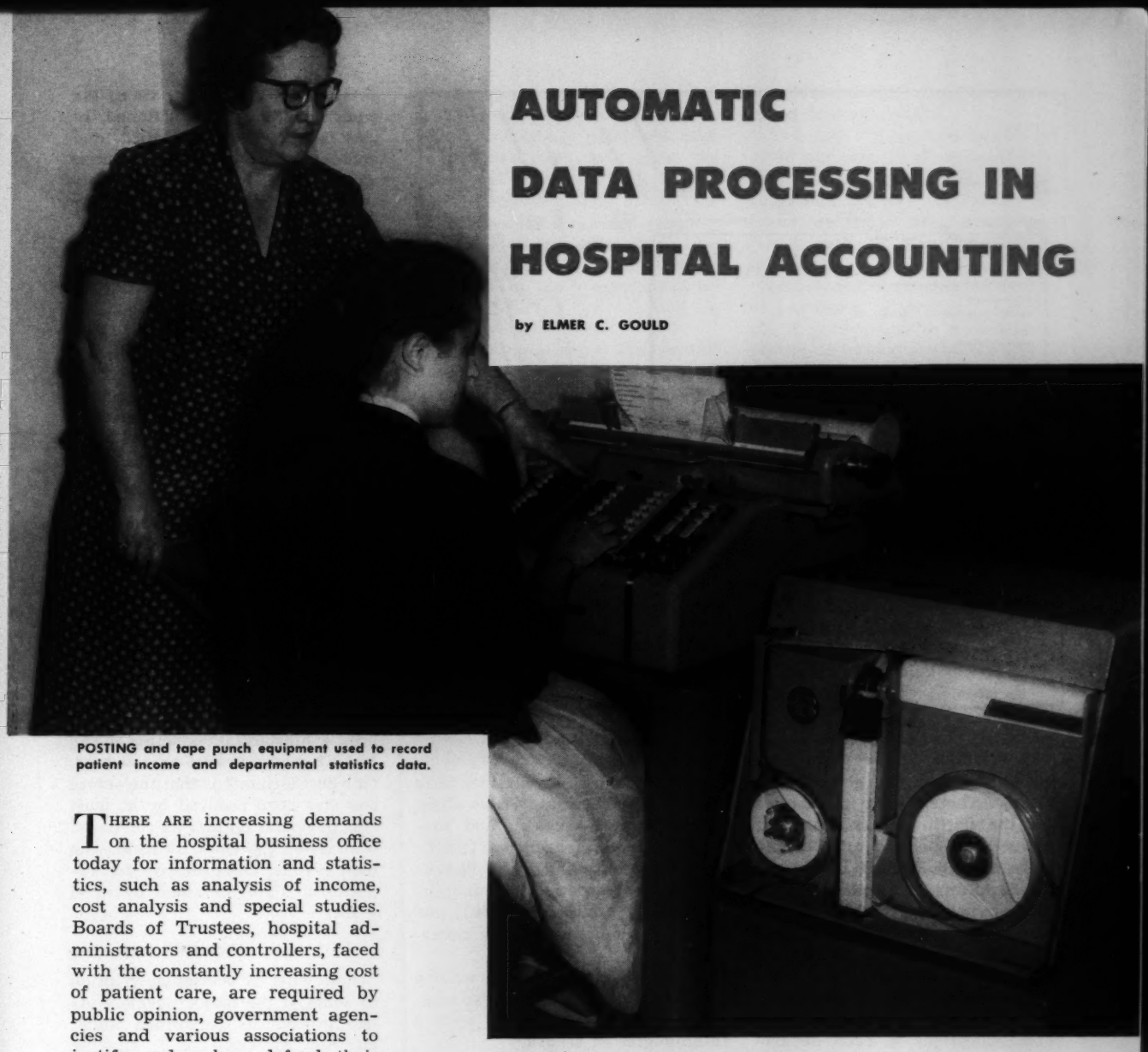
As a form of continuing orientation, employees are encouraged to call telephone station 205, to receive a recorded message of some interest or importance to all members of the hospital staff. By dialing 205, the employee may also record a question, suggestion, or comment of his own. These messages are heard only by the administrative staff member responsible for the communication system, and an answer is given or acknowledgement of the suggestion or comment is made. This acknowledgement is prepared in a telegram form and sent to the individual if he has identified himself, posted on the bulletin board if he has not.

There is a communication center in the hospital, and all employees are encouraged to stop by the communication center as often as they can. The mail-room, official bulletin boards, safety information, and pamphlet racks are in the communication center. Personal conferences with the department head, with the chaplain or the administrator are other means of follow-up.

As changes take place in the hospital, it is necessary that the changes take place also in the orientation session. It is important that orientation procedures be evaluated to determine whether employees are learning things that they want to know and need to know. These evaluations may be made by means of an employee questionnaire, a questionnaire or conference with the department heads and, of course, by assessing over-all morale and individual achievements. ■

AUTOMATIC DATA PROCESSING IN HOSPITAL ACCOUNTING

by ELMER C. GOULD



POSTING and tape punch equipment used to record patient income and departmental statistics data.

Modern data processing methods and equipment, in a 230-bed hospital with 7500 admissions annually, provides administration with complete and detailed patient income data more quickly at the same cost, according to the author. He describes certain equipment features and accounting procedures to show how the program works.

THERE ARE increasing demands on the hospital business office today for information and statistics, such as analysis of income, cost analysis and special studies. Boards of Trustees, hospital administrators and controllers, faced with the constantly increasing cost of patient care, are required by public opinion, government agencies and various associations to justify, and perhaps defend, their cost of operations. As these pressures build up, so does the work load in the business office.

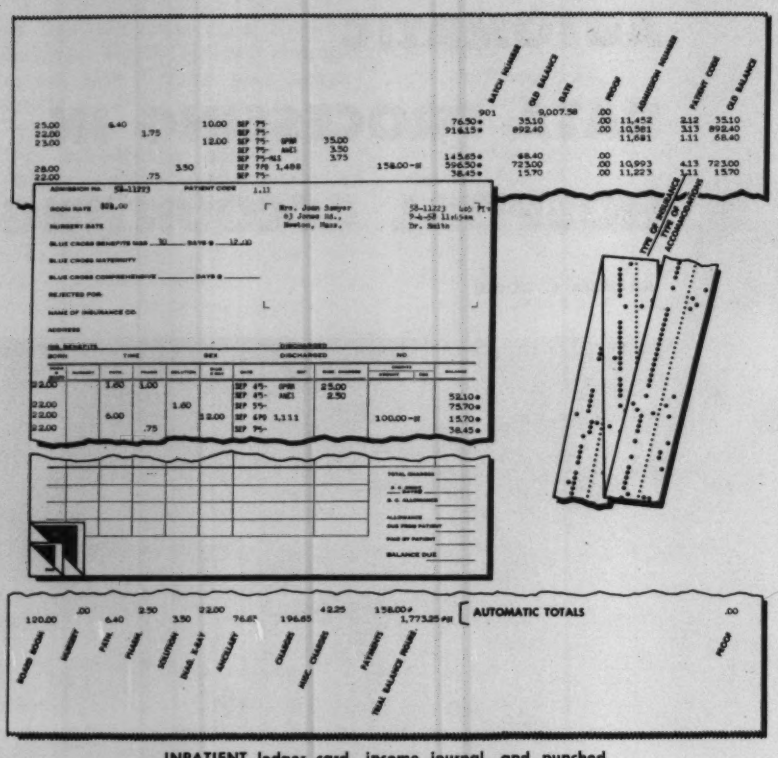
Accounting systems and procedures which were adequate five or ten years ago may be inadequate for today's requirements. Adoption of modern methods and use of modern equipment can lighten the work load of the business office and, at the same time, provide administration with complete and up-to-date information. Machine accounting with automatic data processing is now available to the medium sized hospital at a cost that can be considered reasonable for the results obtained.

Without proper financial reports and analysis of statistics, the hospital administrator is severely handicapped when dealing with the public, government agencies, and other third parties. Automatic data processing can provide him with a volume of detailed information not available otherwise, except at great cost in accounting labor.

Perhaps the most time-consuming paper work in the business office is maintaining accounts receivable, the related analysis of income and statistics. It is this phase of our work that has been adapted for use on a modern bookkeeping machine, plus automatic data processing through an attached tape recording device.

The conversion of income from patient services into accounts receivable, and then into cash, is perhaps the most important operation in the business office. This provides a very substantial por-

Elmer C. Gould is chief accountant at Newton-Wellesley Hospital, Newton Lower Falls, Mass.



INPATIENT ledger card, income journal, and punched tape are posted simultaneously under the new system.

tion of the cash for general operations. Therefore, it is essential that the posting of charges and credits be done promptly, accurately, and efficiently to insure up-to-date billing and collections.

As a byproduct, the posting medium should provide for accurate classification of income by departments, such as routine services, operating room, x-ray, pathology, etc. In addition, there should be subclassifications in each department by inpatient and outpatient services. When posting is done properly, income by routine services, both inpatient and outpatient, and by all related ancillary services can be obtained.

Obtaining patient statistics, such as days of care, outpatient visits and departmental statistics, and number of operations, x-rays and other related statistics, is very important for purposes of comparison, cost analysis and preparing special reports. These statistics should be classified in the same manner as income.

INCOME DATA CLASSIFIED

In addition to these groupings, we have added a total reclassification of all income by what we term "agencies". These are: Blue Cross (medical and surgical, and maternity), public agencies (public welfare, county and state), Workmen's Compensation, commercial insurance (group insurance), and other (without third party coverage).

By these groupings the volume of our services to patients so classified can be determined with a high degree of accuracy.

INCOME DATA ANALYZED

Posting patient accounts, classifying and subclassifying income, reclassifying by "agencies", and recording patient and departmental statistics is done in one operation on an accounting machine with tape punch. All information indexed in the machine is automatically recorded by code on an eight-channel tape. At the end of each day's run, the tape, a copy of the income journal (backing sheet) and a copy of the daily control are sent to a tabulating service company to be processed. This company also prepares monthly reports for the administrator's use.

In this way, detailed reports are obtained; at the same time, the work load has been lightened, so that the services of one full-time and one part-time clerk have been eliminated. In addition, a complete analysis of all payments, allowances, and other credits, is obtained.

We also process a daily "discharge report" from which we get the number of discharges, patient days, medical classifications, cities and towns from which patients were admitted, and "agency" classifications. The "discharge report" is the only extra or separate run that has to be made, and this takes only 20 minutes per day.

TIME AND DOLLARS SAVED

The cost of operating the system is difficult to determine. The saving in personnel, better and more accurate reports, lightening of the work load, and relieving personnel of the drudgery of hand work, all can be considered a gain. The annual cost of data processing is about equal to the salaries of one and one-half clerks, and there has been a substantial reduction in the cost of charge tickets or vouchers. Our best estimate is that the actual cost has been reduced by at least one thousand dollars as compared with doing the work by hand. The final results, however, are far superior to those obtained by hand work.

MAIN PROCEDURES PERFORMED

Following is a brief description of some of the major business office procedures performed under our new system.

1. *Inpatient procedure.* Charge tickets or vouchers originate at the nursing stations. The vouchers flow from the nursing stations to the special services departments to the accounting department. Here, in the accounts receivable section, the vouchers are processed and filed in front of the patient's ledger card.

At the time of posting, the patient's admission number and his code number are indexed in the machine, and these numbers remain in the machine until the new balance is cleared. In other words, the patient's code number is indexed only once, even though there may be several individual postings made (see form above).

Departmental income is coded and recorded automatically by positioning the carriage in 90 per cent of the postings, and by using descriptive keys in the other 10 per cent. All credits are identified and coded by use of descriptive keys. Every transaction posted to the patient's ledger card is automatically recorded by code on the tape. The primary purpose of this is to keep the patient's account current at all times. The secondary purpose is to classify income by departments and subclassifications (patient classifications). This classification is carried out automatically as a byproduct of the posting operation.

2. *Outpatient procedure.* Basically, posting an outpatient account is the same as posting an inpatient account, except that charge tickets or vouchers are not used. The posting medium is an outpatient ledger card that originates in the department where the patient is first seen. The outpatient's ledger card is received in the accounting office complete with dollar amount of the charge, nature of the service rendered, department where the service was rendered, and the units of service (see form below).

The accounting personnel add the patient's code number to his ledger and prepare a bill, if one is to be rendered. The account is then posted in the same manner as the inpatient's. Classifying income by departments and subclassifications is done automatically as a byproduct of posting, just as with inpatient ledgers.

3. *Coding procedure.* No manual coding is necessary for charges, payments or allowances. Our form and posting machines are designed to code every transaction automatically without any extra effort on the part of the operator. This saves many hours of work and results in a high degree of accuracy. Coding is used for three basic types of analysis: departmental income, patient classification (in- or out-), and agencies (types of third party coverage).

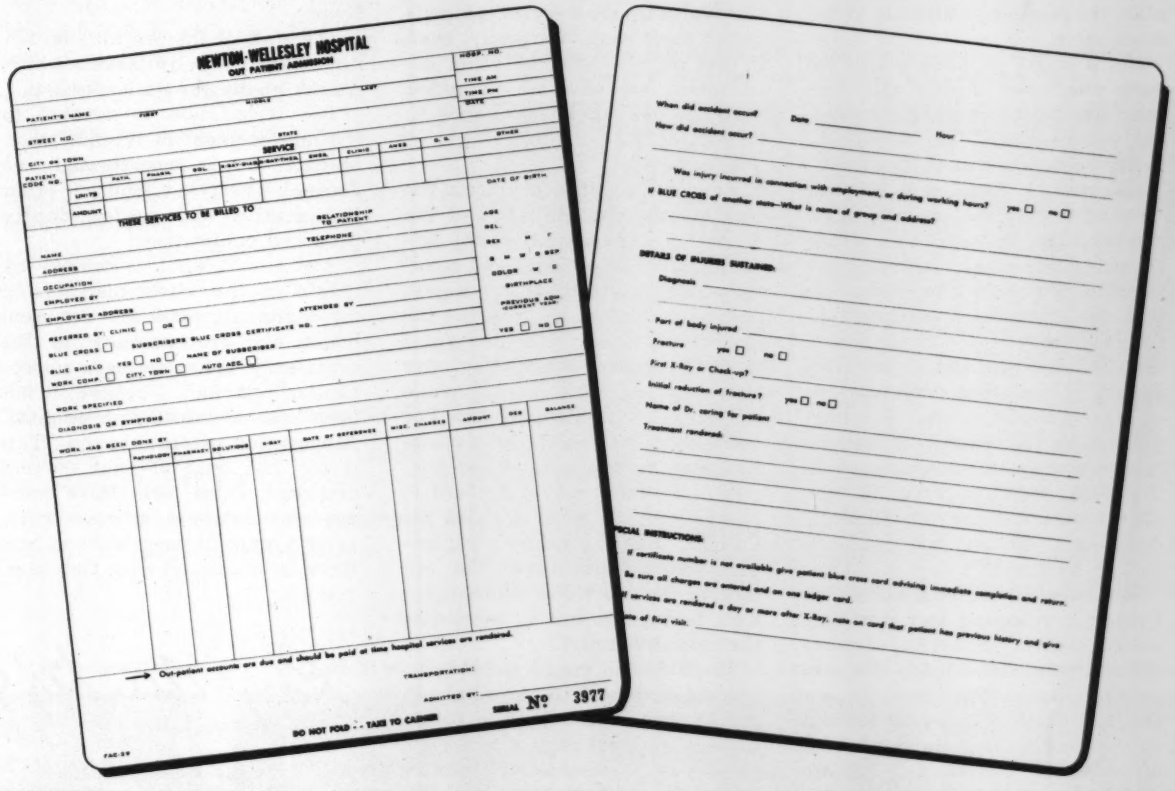
4. *Departmental income and credit procedure.* The form we use is arranged for horizontal posting. The eight columns are headed as follows: room and board, nursery, pathology, pharmacy, solutions, x-ray diagnostic, miscellaneous income, and all credits.

The first six columns handle 80 to 90 per cent of all charges. Column seven is used for 18 miscellaneous income classifications. Some of these are emergency, clinic, delivery room, anesthesia, oxygen, etc. In column eight, all credit transactions are posted, such as payments, allowances, refunds, etc. A symbol key for each type of posting is located in the keyboard. These keys are wired so that, when used for posting, they automatically punch the posting code into the tape.

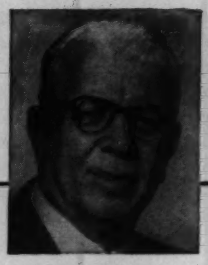
5. *Agency and patient classification procedure.* Since our office analyzes each transaction in terms of "inpatients", "outpatients", "agencies", and "type of accommodation", a simple method of getting data according to these breakdowns is to assign to all patients, a three digit "patient code" number along with the conventional admission number.

The first digit of the code number stands for the following: 1) Blue Cross regular; 2) Blue Cross

(Continued on page 121)


NEWTON-WELLESLEY HOSPITAL
OUT PATIENT ADMISSION
SERVICE
THESE SERVICES TO BE BILLED TO
WORK HAS BEEN DONE BY
Out-patient accounts are due and should be paid at time hospital services are rendered.
DO NOT FOLD - - TAKE TO CASHIER
SERIAL Nº 3977

OUTPATIENT form developed at Newton-Wellesley Hospital contains all data pertinent to business office including insurance report information.



your president reports

THIS IS the last opportunity that I have of writing officially to the entire membership through the medium of this monthly report of the president in **HOSPITALS**, J.A.H.A. As I reflect on the past year, I recall that at times I looked on this column as quite a difficult chore. After all, it is the one regular vehicle by which the president can reach and talk to the entire field about the problems which press upon hospitals during the year of his presidency.

In my term as president, and as monthly columnist, I have expressed my opinion on many phases of hospitals. Throughout, I have tried to bear in mind the importance of the problem, the desire of the membership-readership and the need to outline or explain the position or attitude of the Association.

Not a single problem which we have mentioned during this past year has been completely solved, but progress is, I am sure, certainly being made in all directions.

Recently, I attended a hospital meeting outside the United States. Interestingly enough, the whole theme of this conclave was hospital efficiency—and it seemed to me that the discussants assumed that the hospital was not as efficient a unit as was possible. I am convinced by my own experience as a hospital administrator, and even more so by the remarks of reliable and knowledgeable persons outside the field, that hospitals on the whole have a degree of efficiency comparable to, and not exceeded by, the best in industry.

Recently, at the hospital which I direct, a reluctant and unwilling patient— a very powerful, successful and good man—made this sort of appraisal: "Emergency room was well staffed. Everyone seemed to know his business and did it with dispatch and cheerfulness. X-ray and laboratory were up to standard. The patient rooms were clean, well ventilated, and lighted, and pleasantly decorated and well equipped . . . the personnel, the head nurse as well as the whole team—residents, interns, nurses, aides and housekeepers—gave the feeling that care was complete. All were well oriented and trained to do their work well and to give the best patient care, thinking all the while to make the patient comfortable." This man, an unwilling patient, was not surprised because he had heard again and again that this was the way hospitals were. And so he complimented all for their efforts on behalf of his successful stay and recovery. The picture he painted is not a picture of one hospital, but is typical of American hospitals devoted to the survival and recovery of patients under their roofs. Certainly, even if this picture reflected some inefficiency, we who are identified with the field should be happy to be part of it.

OF GREAT significance during the past months was the move of the American College of Hospital Administrators into their new quarters at our Association's headquarters building. We welcome the College's return to close living and to the liaison which for five years has not been possible while we were at separate addresses. For more than 25 years, the College has been such a part of our hospital life that it would be hard to conceive of our work without the College. It is the prime organization devoted exclusively to enlarging the individual administrator's leadership and to expanding the executive mind.

Much of the credit for the increased status of the hospital administrator must be given to the College as well as to the formal university courses and training programs. The College has had high sights and splendid leadership from its officers and staff. Certainly, the Association and the College should gain from this fine atmosphere and complement one another by close contact.

Finally, I come to the end of my last presidential column. And I could not possibly end this epistle without paying real tribute to those who do the bulk of the work of the Association—the delegates and the members of the councils and committees. It is the membership which provides the leadership in our programs and it is the staff which carries it out. I think we have a totally dedicated staff, as I have so often said to those at headquarters with whom I work so closely—Dr. Crosby, Mr. Norby, Dr. Brown, Mr. Hague and Miss Ryan.

The staff of the Washington office renders a daily service which speaks highly for its leadership.

The Association is devoted to the improvement of hospital care. Much of this is done through our Journal, **HOSPITALS**, and our other informative and professionally produced publications.

And now, I want to express my thanks to the whole membership for conferring upon me the great honor and responsibility of the presidency. It has not been a spectacular year, but, I believe, it has been one of substantial progress. "Swans sing before they die." This is the last song of your current president. Good luck! Have courage and fortitude in your work, perseverance in your desire to help those in need, and may God bless you all.

Ray Amberg

Ray Amberg, president
American Hospital Association

engine power
BY CATERPILLAR

WHY THIS HOSPITAL'S STAFF RARELY KNOWS WHEN POWER FAILS

Within two months, Clay County Hospital in Flora, Illinois, had eight power interruptions. But rarely did staff members know they had happened. Because when utility power fails, a Caterpillar D326 Diesel Electric Set automatically takes over the load in seconds. With a 100 KW generator, the Cat standby power unit provides all the power needed in this 52-bed hospital for two iron lungs, extensive X-ray equipment, electric motors, an elevator and two 75 HP boilers.

Nothing stops when power fails because automatic starting controls swing the D326 into action. It operates until power is restored and then automatically stops. This is *dependable* power—the kind a hospital must have. And it comes with the most dependable parts and service facilities you can get.

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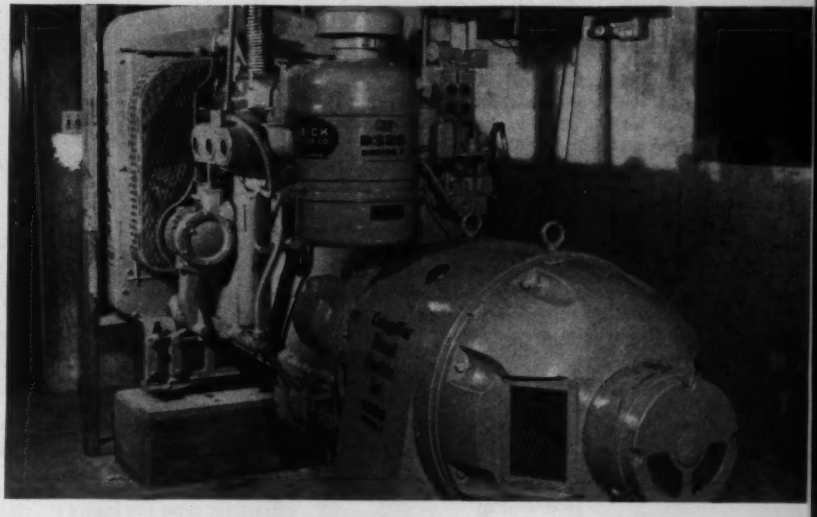
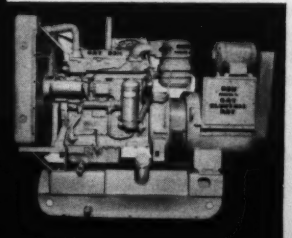
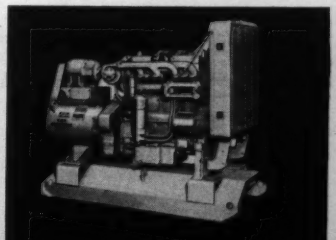


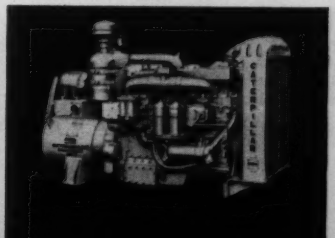
The D311, 30 KW continuous power



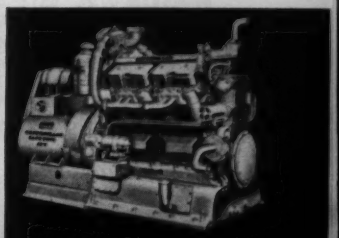
The D315, 60 KW standby power



The D326, 115 KW standby power



The D375, 250 KW standby power



ASSOCIATION SECTION

The following actions were taken by the Board of Trustees of the American Hospital Association at its meetings in Chicago on May 18-19, 1959. Further actions of the Board will be reported in subsequent issues of this Journal.

COMMITTEE ON LISTINGS

***VOTED:** To approve the recommendations of the Committee on Listings for listing of the following hospitals:*

ALABAMA

Baugh-Wiley-Smith Clinic and Hospital, Decatur.

Fayette County, Fayette.

ARKANSAS

Stuttgart Memorial, Stuttgart.

CALIFORNIA

Crescent Bay Convalescent, Santa Monica.

Balowen Convalescent, Van Nuys.

Sherman Way Convalescent, Van Nuys.

Sher-Wood, Van Nuys.

Valley Presbyterian Hospital-Olmsted Memorial, Van Nuys.

FLORIDA

General Hospital of Greater Miami, Coral Gables.

Okaloos Memorial, Crestview.

Waterman Memorial, Eustis.

The J. Hillis Miller Health Center, University of Florida, Gainesville.

Sunland Training Center, Gainesville.

University of Florida Infirmary, Gainesville.

Hialeah, Hialeah.

James Archer Smith, Homestead.

Monroe General, Key West.

Lake Shore, Lake City.

Theresa Holland, Leesburg.

Suwanee County, Live Oak.

Madison County Memorial, Madison.

Brevard, Melbourne.

Everglades Memorial, Pahokee.

Glendale, Palatka.

Gadsden County, Quincy.

Federal Correctional Institution, Tallahassee.

Hillsborough County Home and Hospital, Tampa.

Valparaiso Bay, Valparaiso.

ILLINOIS

Bethesda, Chicago.

Forest Sanitarium, Des Plaines.

Tinley Park State, Tinley Park.

LOUISIANA

Student Hospital, Louisiana State University, Baton Rouge.

Bogalusa Community Medical Center, Bogalusa.

Gonzales, Gonzales.

Plaquemine Sanitarium, Plaquemine.

MINNESOTA

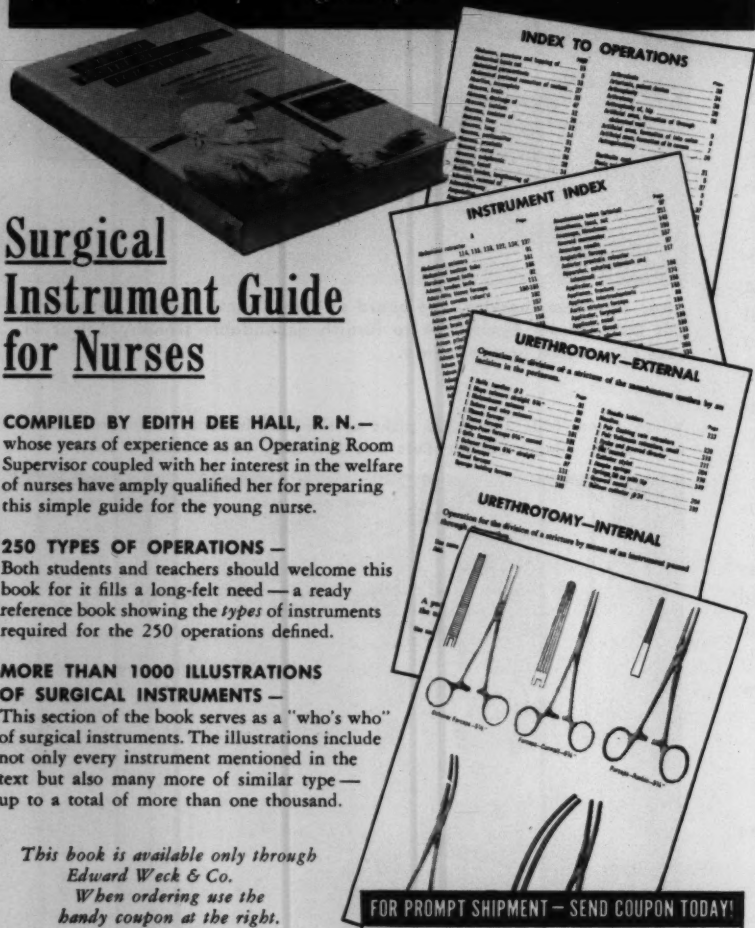
Waseca Memorial, Waseca.

MISSISSIPPI

Aberdeen, Aberdeen.

(Continued on page 122)

"This orderly book will save many an hour and many a headache for the operating room personnel" — HOSPITAL TOPICS



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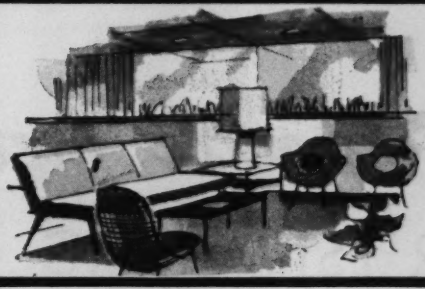

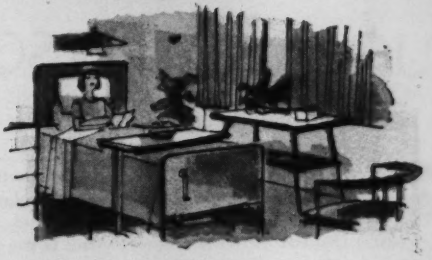

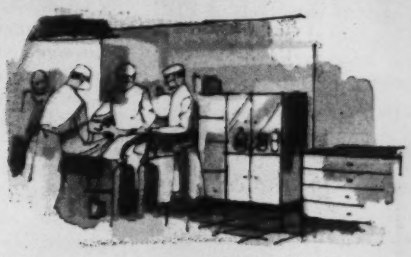

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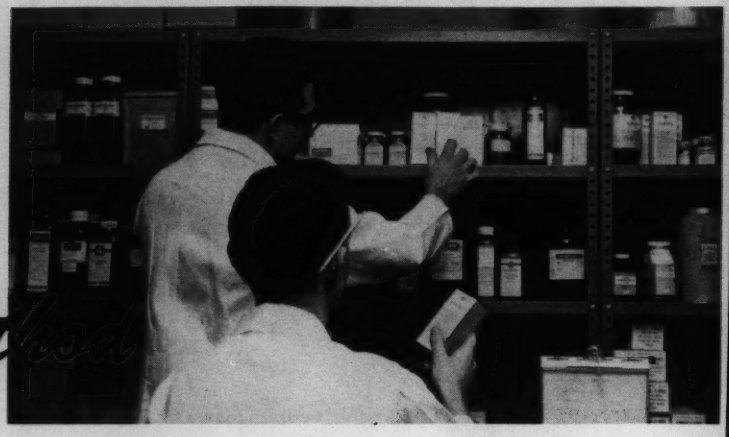

Composite method FOR ESTIMATING DRUG AND PERSONNEL NEEDS

by LEO JOEL

Two methods for estimating the pharmacy budget, including both drugs and personnel, are described by the author. One is the workload, unit cost method, based on past experience; the other is a standards method, based on professional judgment. The former method has some advantage over the latter, according to the author, because it provides objective data for consideration when preparing the budget.

THIS PAPER presents the method of estimating pharmacy drug and personnel requirements used in U. S. Public Health Service hospitals and outpatient clinics.

The Division of Hospitals of PHS operates 12 general hospitals, one tuberculosis hospital, two neuropsychiatric hospitals specializing in treatment of narcotics addicts, and the National Leprosarium at Carville, La. The general hospitals vary in size from 130 to 800 beds. Besides inpatient services, they provide services to almost 600,000 outpatients a year. Full-time outpatient clinics are also operated in cities with significant numbers of PHS beneficiaries but no service hospital. These 26 clinics handle about 500,000 visits a year.

Pharmacy service for all these facilities involves compounding and dispensing drugs, costing over a million dollars per year wholesale, and employing 60 pharmacists and 25 supporting personnel to carry on pharmacy operations. In addition to filling the pharmacy requirements of the parent station, most hospital pharmacies do bulk compounding and prepackaging to effect economies in supplying smaller stations. Only six outpatient clinics have their own pharmacies. The others receive a large part of their supplies from hospitals located near them.

The hospital pharmacist is responsible for participation in staff and pharmacy committee meetings; consultations on drug therapy problems; requisitioning of supplies; maintenance of inventory records; and preparation of monthly reports on stock control, drug costs, and workloads. All chief pharmacists contribute importantly to their hospitals' over-all training programs by using their specialized knowledge for the education of physicians, dentists, dietitians, etc.

Leo Joel is chief, Financial Management Branch, Division of Hospitals, U.S. Public Health Service.

FINANCIAL REQUIREMENTS

The budget process may be explained, in operational terms, by outlining its purposes as follows:

1. To plan and forecast the operation for the budget period in financial terms.

2. To coordinate segments of the budget plan so that the whole program will proceed in a unified manner within the total available resources.

3. To control use of funds so that operations do not result in costs which exceed resources and to provide for contingencies which had not arisen or were not taken into account when the financial plan was prepared.

The first of these purposes, forecasting the cost of drugs and personnel for the pharmacy operation, is the prime concern of this paper. For this, recent experience is a valuable guide. If an operation is progressing efficiently and economically, then it may be assumed that the same level of cost will be carried into the following period. When records can be used to support this, and a logical forecast of workload can be developed, a program budget based on a workload-unit cost approach is the most objective. We calculate requirements by using the following formula:

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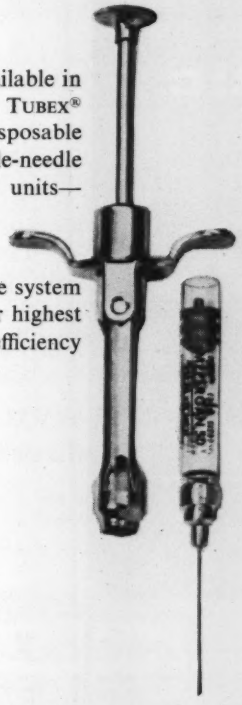

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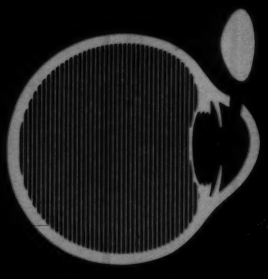

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ZOLYSE reduces operative and post-operative complications.

ZOLYSE is safe with no known contraindications in patients over 20.

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[1]Girard, Louis J., and Neely, Wanda: "The Evaluation of Zolyse in Cataract Extraction", Research Report No. 11, Alcon Laboratories, Inc., 1959.

[2]Boyd, Benjamin F.: Enzymatic Zonulysis, Highlights of Ophth., vol. III, no. 4, pg. 70, 1959.

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Number of items times unit cost equals financial requirement.

Unit cost and workload estimates should be related to past experience. Any change in either of these needs to be clearly expressed.

VARIABLES AFFECTING BUDGET

In some situations, where operations are so varied that the recording of workload and cost experience becomes a task involving substantial effort, the operating officer may properly decide that the time required for such reporting could be better spent for some operational purpose rather than for record keeping. This decision will lessen the degree of objectivity of the budget forecast. However, lacking complete data (for instance, manpower utilization figures), the forecast can be based on a standard reflecting the responsible officer's analysis of the work to be done, or a short term study, or an approximation based on over-all experience.

The forecast based on complete records, because it provides a logical development of the financial requirement, is superior to that based on standards. It also simplifies discussion and evaluation of the request since differences of opinion are obviously limited to objective numerical factors which become a matter of record, and possible future adjustment can be made if need should arise.

In forecasting financial requirements for pharmacy operations in PHS hospitals, both methods are used. Drug requirements can be derived, on a unit cost-workload basis, by use of available records, kept as a necessary part of the pharmacy operation. In the personnel budget, however, varied tasks, geographical dispersion, and relatively small operations make the recording of time utilization uneconomical. Budgeting for personnel, therefore, is based on a standard to be described in the section treating that subject.

THE DRUG BUDGET

The drug request is one item of the requirements for "other objects" (expenses other than personnel). All requests must be reviewed simultaneously to accomplish the "second purpose of budgeting," which is to coordinate the budget plan so that the whole program will proceed in a uniform manner within the total resources available. Reviewing a number of different items requested by 16 hospitals requires a presentation which will summarize the needs of the pharmacy group as objectively as possible. In the Division of Hospitals, relating the experience and the estimate for inpatient and outpatient costs to the cost per inpatient day and the cost per outpatient visit respectively accomplishes this.

A form which may be used for internal station analysis or annual submission, is shown in Figure 1. Column B furnishes data for the completed quarters of the current fiscal year. Its primary purpose is to provide a record that can be compared with column C (which shows data for the last two months) in order to determine whether there are changes which warrant further analysis. Column D gives an estimate for the current month in order to complete the data for the current quarter, which then becomes the basis for estimating requirements for the next quarter.

The stub column is divided into two sections. To complete the first, made up of lines 1 through 5, the average daily patient load and the costs of drugs are used. This provides data for the basic calculation of budgeting (i.e., workload times unit cost equals total cost). Although line 5 results from line 3 times line 4, it is appropriate to determine line 4, the cost per inpatient day, for the experience period, by dividing line 5 by line 3. To complete the second section,

QUARTERLY OR SUPPLEMENTAL REQUEST FOR DRUG FUNDS

Approved by MOC _____ Date of Request _____

Actual Issues _____ Estimated Issues _____

Type of Item (A)	Total Prior Quarters (B)	Two Months Current Quarter (C)	Last Month Current Quarter (D)	Total Current Quarter (E)	Total Cumulative (F)	Requirements Next Quarter (G)
1. Average Daily Inpatient Load						
2. Number of Days in Period						
3. Total Days of Inpatient Care (line 1 times line 2)						
4. Cost of Drugs per Inpatient Day						
5. Total Cost of Inpatient Drugs (line 3 times line 4)						
6. Total Outpatient Visits						
7. Cost per Outpatient Visit						
8. Total Cost of Outpatient Drugs (line 6 times line 7)						
9. Total Drug Costs (line 5 plus line 8)						

ANALYSIS OF PURCHASES AND ISSUES

A. Inventory value June 30 _____ a	$_____	
B. Deliveries from prior year purchases	_____	
C. Current year purchases (obligations)	_____	
D. Less: Undelivered current fiscal year orders	_____	
E. Total available		$_____
F. Less inventory value as of _____ b		_____
G. Total usage		_____

a. End of last complete fiscal year.
b. Inventory at end of last complete month.

lines 6 through 8, a similar calculation is performed. This furnishes a record of past experience and projects the requirements for future outpatient visits. Line 9 states the total drug cost.

THE DRUG INVENTORY

Below the stub column is an inventory reconciliation, which expresses the relation between purchases, inventory, and issues analytically. Item G of this section should be generally reconciled (absolute agreement is not insisted on) with the sum of columns B and C on line 9. To complete this section, take the opening inventory as a starting point, adjust for purchases and undelivered orders (all a part of normal record), and use the closing inventory to explain the fund flow as applied to the utilization of the drug dollar. Drug usage so determined will not correspond with actual drug issues when, for instance, there is a gain or loss through the transfer of excess supplies to or from the station; then records must be adjusted to the actual physical inventory. Appreciable discrepancies, (say one half of one per cent) should be explained.

EVALUATING THE METHOD

Future workload estimates are supplied by a statistical branch of the headquarters, but the station may propose a change in estimated workload. Such proposals, if properly supported by explanation, are generally approved.

This description of the drug estimation process would not be complete without a discussion of its defects and of the results of its use. Three possible criticisms may be stated as follows:

1. It oversimplifies a complex of workload and unit cost factors, and using it may distort the facts.
2. It tends to base allowances on past experience.
3. It does not expose wasteful or substandard operations.

Regarding the first, this method supplies a base for analysis, discussion, and justification of proposed variations of workload or unit cost.

In answer to the second, the formula will support estimating on the basis of past experience. If a change is necessary, further analysis will show and explain why more funds are needed, and how the future will differ from the recent past, or—after the formula has been used for a time—from earlier experience.

The requests do come from a number of stations, but the last criticism is met because their operations are reviewed qualitatively on location by responsible, professional officials, who know the unit costs of other stations and have the competence needed to determine reasons for variations among stations and to adjust inequities in the program.

This method of determining the drug budget has been well received both in the field and at headquarters, and has accomplished its objective to the satisfaction of both.

THE PERSONNEL BUDGET

The fact that the clinic pharmacist often has administrative duties not related to the pharmacy program prevents formulating a generally applicable method of estimating personnel requirements. Even in the hospitals, the varied tasks of the pharmacists, in the context of differences in the mission of the various hospitals, makes a situation where complete recording of time utilized on specific operations would take more effort than appears to be warranted by the potential results.

STAFFING STANDARD

The situation requires, therefore, a budgeting approach on the basis of a staffing standard. The measurable and nonmeasurable workload of these stations has been studied and a standard of staffing developed. This standard, after due allowance for leave, proposes progressively increased productivity, beginning with one pharmacist for the first 30,000 units of work, another for the next 35,000 and similar increases thereafter. This allotment of personnel provides sufficient time for the nonmeasurable tasks described earlier. Supportive personnel are allowed at the rate of one nonprofessional person to every two pharmacists.

This standard reflects a substantially greater productivity than is usual for a voluntary hospital pharmacy operation. This is possible because the pharmacies of the division carry a relatively large workload of prepackaged items and issues to nursing units (28 and 42 per cent respectively of the total 1957 experience).

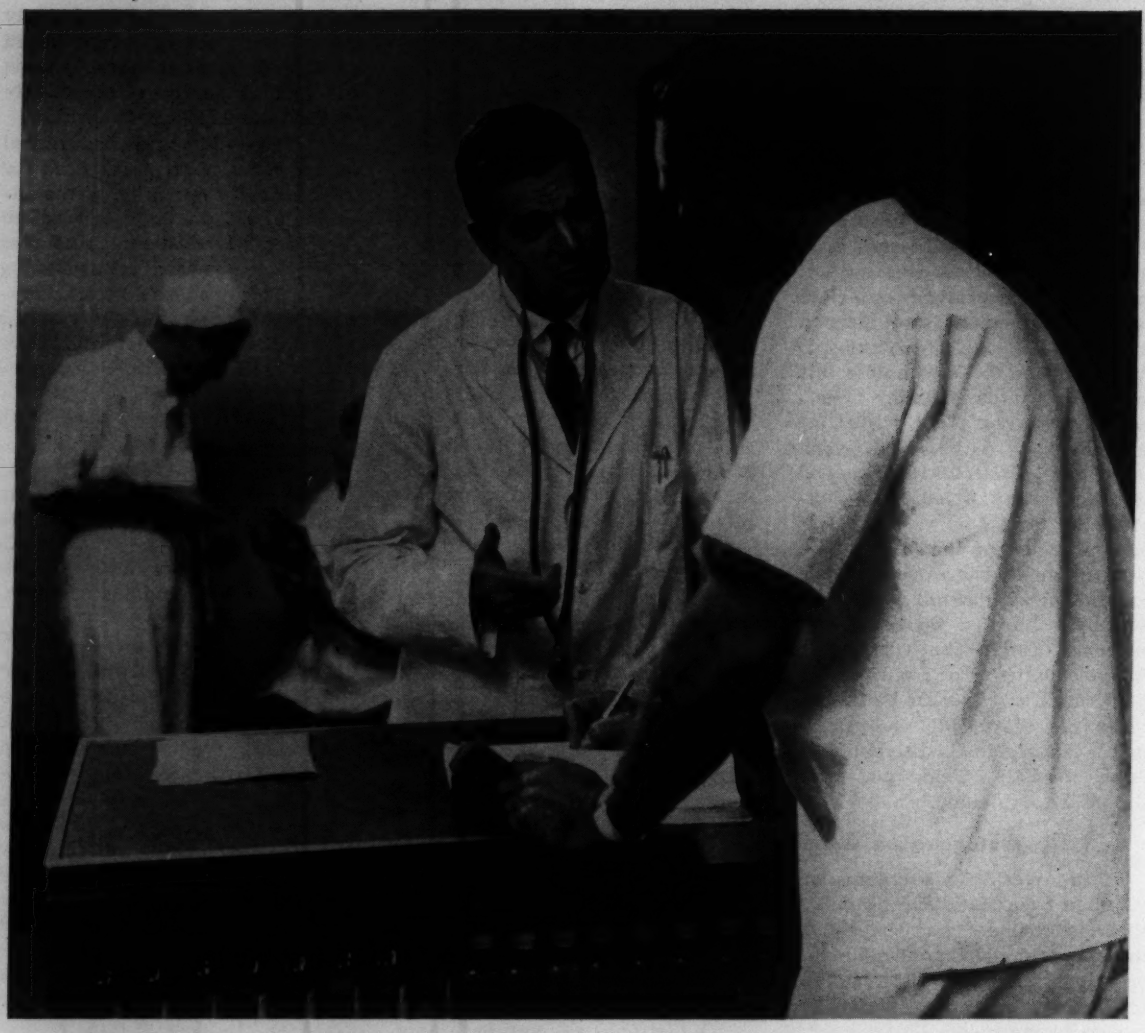
By these standards, additional manpower support is required for the pharmacy operation of the Division of Hospitals. The situation improves as additional resources are directed toward better staffing ratios. However, the basic standard needs concrete support in the form of specific determinations about necessary functions, now unperformed, which will be assumed with the added staff. With such information, possibly obtained by short term utilization studies of individual operations, sufficient evidence of need can be put before reveiwing bodies for their use in determining the rate of support in this area.

SUMMARY

The budget mechanism of the PHS Division of Hospitals for drugs and pharmacy personnel represents two methods of approach to the problem of forecasting financial needs. Both use a workload unit cost presentation. In the case of the drug budget, the projection is based on past experience, but the basis for the personnel request is a formal standard.

The greater objectivity of the former wins a more favorable reception. It also makes a more forceful presentation because differences between submitting and reviewing bodies are limited to specific workload and cost items, expressing past experience numerically and affording specific comparison with estimated items when the estimates period arrives.

The standards approach to the problem of forecasting financial needs depends strongly on authority and professional judgment. Due weight must be given to these, but such an estimate must compete with others for its share of a set total of funds and is likely to need the support of concrete examples showing inadequate performance because of lack of funds. Accordingly, a change to an experience based presentation is advisable if it can be economically developed.■



"YES...I HAVE SPECIAL REASONS FOR SPECIFYING BUFFERIN"

There are a lot of reasons why so many physicians specify Bufferin. For instance, it's *better tolerated* than plain aspirin—many times better tolerated according to one recent study[1] of 236 patients. Therefore, it's the choice when high-dosage or long-term salicylate therapy is indicated. And Bufferin *contains no sodium*—so it's ideal for effective pain relief when the patient's on a low-salt or salt-free diet.

Bufferin makes work easier for the hospital staff too: no stomach upsets to waste nursing time—the fast onset of action means fewer of those "why don't I feel better yet" calls.

And the new 1,000 tablet hospital size bottle of Bufferin means that you can now economically stock this fine analgesic for general hospital and out-patient use. Be sure it's available in your pharmacy.

Each Bufferin tablet combines 5 grains of aspirin with Di-Alminate (Bristol-Myers' name for the exclusive combination of the antacids aluminum glycinate and magnesium carbonate).

1. Sher, D. B.: Aspirin and APC Irritation of the Stomach, Scientific Exhibit, World Congress of Gastroenterology; Washington, D.C., May, 1958.

BUFFERIN® 1,000's save money · save space · save time

ANOTHER FINE PRODUCT OF BRISTOL-MYERS

ANESTHESIOLOGIST DEVELOPS IMPROVED PORTABLE SUCTION UNIT

by ANTHONY J. MARANGA

PORTABLE, gas-operated suction unit designed by hospital anesthesiologist for use in corridors and elevators with pre- and post-operative patients.

Since pre- and post-operative patients, through aspiration of foreign material, may develop respiratory distress in elevators or corridors, adequate suction must be quickly available to prevent other complications or even death. The author describes the development by an anesthesiologist and a consulting engineer of a portable suction unit to handle these emergencies.

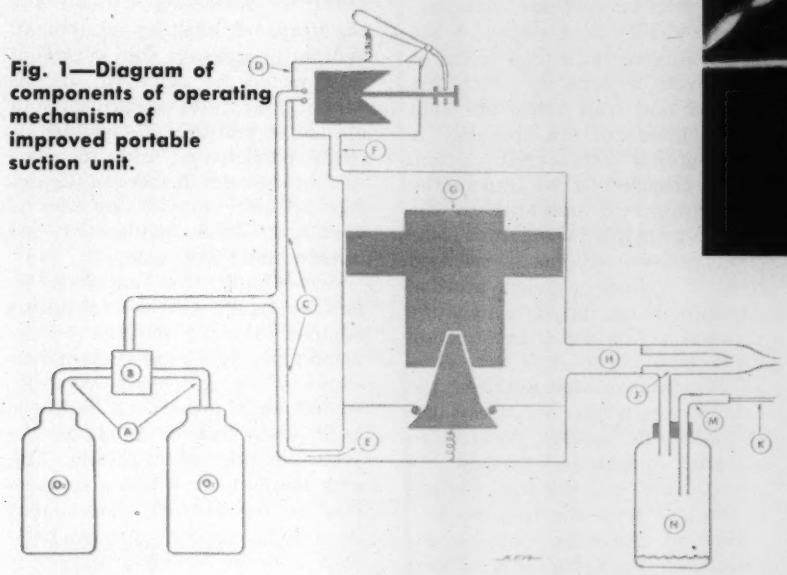


Fig. 1—Diagram of components of operating mechanism of improved portable suction unit.

LEGEND
A—DOUBLE YOKE
B—PRESET REDUCING VALVE
C—CHANNEL FROM VALVE TO ACTUATOR LEVER MECHANISM
D—ACTUATOR LEVER MECHANISM
E—PNEUMATICALLY-CONTROLLED VALVE
F—CHANNEL FROM VALVE TO CYLINDER
G—PNEUMATIC CYLINDER
H—VENTURI MECHANISM
J—CONSTRICTION SITE OF VENTURI
K—CATHETER
M—CHANNEL FROM CATHETER TO TRAP
N—TRAP BOTTLE

THE INFECTIOUS nature of progress manifests itself in many unexpected and surprising forms. Such was the case at St. Barnabas Hospital when our current development program, which includes the construction of a surgical suite housing four additional operating rooms and related facilities, resulted in the design and construction of an improved portable mechanism for aspiration and resuscitation. The suction equipment was devised through the joint efforts of our director of anesthesiology and the consulting engineer retained to design equipment to meet the specialized needs of our surgical staff.

Anthony J. Maranga is assistant director, St. Barnabas Hospital for Chronic Diseases, New York.

The anesthesiologist's original function in this association was to interpret surgical needs to the engineer, so that the engineer could design modern apparatus for operative intervention, to facilitate anesthetic monitoring, and that would be adaptable to present and contemplated research projects. Much of the equipment was designed and custom-built, although in some instances standard equipment was modified to meet requirements.

These achievements served as a stimulus for the anesthesiologist to review and analyze the armamentarium now available for staff use with surgical patients at the hospital. The surgical suite was equipped to meet all foreseeable physical needs. Qualitative as well as quantitative laboratory, radiology, physical therapy, and related services were available at all times. Nursing staffing patterns and personnel assignments were geared to a high caliber of care and treatment at the patient's bedside as well as in related areas of the hospital. In summary, all of the essentials of an ideal program and physical facility were in abundant evidence.

EMERGENCY SUCTION UNIT NEEDED

The problem still remained, however, of insuring that suitable portable suction devices would be constantly ready for patients needing such equipment. The pre- or post-operative patient carried on a stretcher through corridors and in elevators, for example, could become a serious risk if adequate suction were not immediately available.

Aspiration of foreign material is a primary complication of anesthesia and surgery, and may develop also under other circumstances. Resulting broncho-pulmonary complications may show symptoms common to various disease entities. Some patients tend to regurgitate or retch when radiologic procedures such as pneumoencephalograms, gastrointestinal studies, intravenous pyelograms, or skull plates are done. Similar symptoms may develop during clinical laboratory procedures. The seriousness of aspirating foreign material has been documented by Keating who states that this ". . . occurs more frequently than is realized, and is often hidden in hospital records as atelectasis or even cardiac arrest."[1]

DEVICES COMMONLY USED

Present mechanical devices for aspiration and resuscitation operate either by electricity or compressed gas. Since the electrically operated device requires an adequate and constant power supply, it is available only in fixed locations of the hospital. Within recent years, piped-in oxygen, suction, and nitrous oxide have been installed in many existing hospitals and are included in most new construction. It is difficult, however, to have such facilities available at all points—in corridors or elevators, for example—where emergencies require immediate measures. Two types of gas-operated portable devices, which may be fastened to stretchers or carried in hand, are available for this purpose. These are:

1. A suction catheter, approximately ⅛-inch in diameter, is attached directly to a trap bottle of 6 to 8-ounce capacity. Both the catheter and trap bottle are held in the hands of the operator. A lever, giving instant full suction, is also attached to the trap bottle. This equipment operates on the venturi principle.[2] Oxygen or some other compressed gas is released from a cylinder under positive pressure, is converted to negative pressure at the site of constriction —the trap bottle—and acts as a pulling force at the point of the catheter tip, which is inserted into the patient's mouth. As foreign material is aspirated through the catheter and into the trap, the gas is released from the trap bottle.

Several problems may be encountered in using this device, however, because the operator is required to use two hands—one for inserting and retaining the catheter in the patient's mouth, and the other for holding the trap bottle and operating the lever. Excess gas or emesis released through the trap bottle may spray over the patient or the operative field. Also, the size of the trap bottle is limited because it must be held in the operator's hand.

2. The second type also operates on the venturi system. The trap bottle is fixed to the stretcher, however, and a needle valve is used for suction control. A long catheter extends from the trap bottle to the patient's mouth. This system eliminates the possibility of spraying excess gas or emesis over the operative field or the patient. A larger trap bottle may be used because the operator need not hold it in his hand, and, once he has opened the suction control valve, only one hand is needed to hold the catheter to the patient's mouth.

Disadvantages of this operation include lack of full suction until the valve is opened completely, loss of suction control at the aspiration site because of the remote location of the needle valve, and wastage of gas while the needle valve is being turned fully on and off.

NEW SUCTION UNIT DESIGNED

The anesthesiologist felt that if a portable suction mechanism could be developed without the handicaps of existing equipment, another progressive step in patient care would be achieved. In his role of interpreter of surgical staff needs, the anesthesiologist had already participated with the consulting engineer in successfully designing and constructing special operating room equipment not commercially available.

Accordingly, the anesthesiologist met again with the consulting engineer for the purpose of developing a new type suction machine. Working models were designed, built, tested, and improved until the desired product was achieved (see photograph). This new mechanism, which also operates on the venturi system, may be used as an independent portable unit, as an integral part of a wheeled stretcher, or may be modified for attachment to piped-in oxygen outlets. It fits compactly under a stretcher without hampering operation of the stretcher mechanism. It presents no transport problem because it does not protrude beyond the over-all width or length of the stretcher nor does it hamper floor clearance needs.

A catheter is attached by means of a heavy-walled, nonkinking transparent plastic tubing, ⅜-inch

in inside diameter, to a one-quart trap bottle which is fitted into a holding bar at the site of the suction mechanism. The other end of the catheter may be placed on the stretcher near the patient's head. A thumb-operated, remote control, actuator lever, located at the point where the catheter meets the heavy-walled tubing, permits the operator to use the same hand to insert the catheter into the patient's mouth and direct the suction flow simultaneously. The actuator lever enables the operator to give an even level of instantaneous full suction without risk of spraying excess gas or emesis over the patient or the operative field.

Two "spaghetti" type, color-coded (red and yellow) plastic tubes of small diameter are bonded to the outer surface of the thick-walled transparent tubing. These are connected to the actuator lever and serve as a circuit for the transmission of compressed gas to and from a pneumatic cylinder which permits the venturi mechanism to function (see Figure 1).

OPERATED BY COMPRESSED GAS

The compressed gas passes through a preset reducing valve (B) to the actuator lever mechanism (D) and to the pneumatically controlled valve (E). When the actuator lever is depressed, the gas, under positive pressure, is carried to the pneumatic cylinder (G), where it forces the cylinder piston downward, permitting passage of compressed gas through the valve into the venturi mechanism (H). At the site of constriction on the venturi mechanism (J), a negative pressure exists in a tube connected to trap bottle (N). This negative pressure draws foreign materials into the trap bottle (N).

Remote control of the basic equipment provides definite operating advantages:[3]

- Easier manipulation of catheter tip and aspiration tube.
- Control of suction at the aspiration site.
- No risk of spraying excess gas or emesis over patient or operative field.
- Instantaneous full suction.
- Wastage of cylinder gas minimized because of instantaneous suction which may be stopped when desired.
- Trap bottle size not limited.
- Trap bottle removed from aspiration site.
- Increased visibility at aspiration site.

The machine also may be adapted to piped oxygen lines in case power failure precludes using electrically operated suction mechanisms, or it may be operated with compressed air cylinders. It could be used as mobile equipment in ambulances, fire engines, and police emergency cars which, currently, rely on battery powered devices.

The evolution of this new mechanism was an unanticipated dividend of our development program, and it has served as an impetus for additional research and study by the department of anesthesiology. ■

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NOTES AND COMMENT

'Staph' survives on blanket fibers

Investigators of "staph" infections in hospitals have always found pathogenic staphylococci in woolen blankets, which are a major source of hospital dust. It is thought that the organisms are transmitted by direct contact and by the traveling clouds of fluff that result from the process of bed-making.

Recent experiments in Australia set up to show the dissemination of *Staph. aureus* from infected blankets indicate that staphylococci survive on wool fibers for at least two weeks. These experiments, reported by K. F. Anderson, M.D. and R. A. W. Sheppard in the March 7, 1959, issue of *The Lancet,* also confirmed that the dust containing these wool fibers is disseminated both by sweeping and by blanket-shaking, and is thus a major factor in the spread of infection.

It was stressed that such experiments must be related to bed-making and that sampling methods must be able to detect falling fibers in the area where blankets are shaken. Otherwise, infected fibers may escape unnoticed.

While it was recommended that hospital blankets be included in any "staph" reduction measures, it was not suggested that blankets were the only carriers of "staph"; the nasal carrier, the dissemination from skin and clothing, airborne infections from several sources and contact with infected bedding were also cited. ■

Medical record education program announced

Plans for an educational program available to all medical record personnel in the United States have been announced by the American Association of Medical Record Librarians.

The program is designed to give basic training to medical record personnel, few of whom have had the advantage of formal education in one of the 30 approved schools offering courses in medical record science. The program will be established with the aid of a Kellogg Foundation grant.

The program will take the form of an extension-correspondence course to be completed on an in-service training basis. The course will include 25 lessons and a final examination. Course content will cover medical terminology, coding of diseases and operations, and forms and methods of medical record keeping.

The AAMRL recommends that after nine months of enrollment in the course the student should attend one of the laboratory sessions to be held at central locations throughout the country. These sessions will be devoted to discussing and clarifying the content of the course. Students successfully finishing the planned course of study will be given a certificate of completion by the association. ■

NEW RESEARCH SHOWS LINOLEIC ACID ESSENTIAL TO INFANT NUTRITION

Hansen's and co-workers' research [1,2,3] on linoleic acid indicates these three important facts:

I. Linoleic acid is essential in infant nutrition.

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Baker's Modified Milk provides 6% of the calories as linoleic acid — an important factor in Optimum Nutrition.*

* providing all the normal dietary requirements plus a reserve for stress situations.

1. Wiese, Hilda F., et al.: J. Nutrition 66: 345, 1958
2. Adam, Doris J. D., et al.: Ibid.: 555
3. Hansen, A. E., et al.: Ibid.: 565

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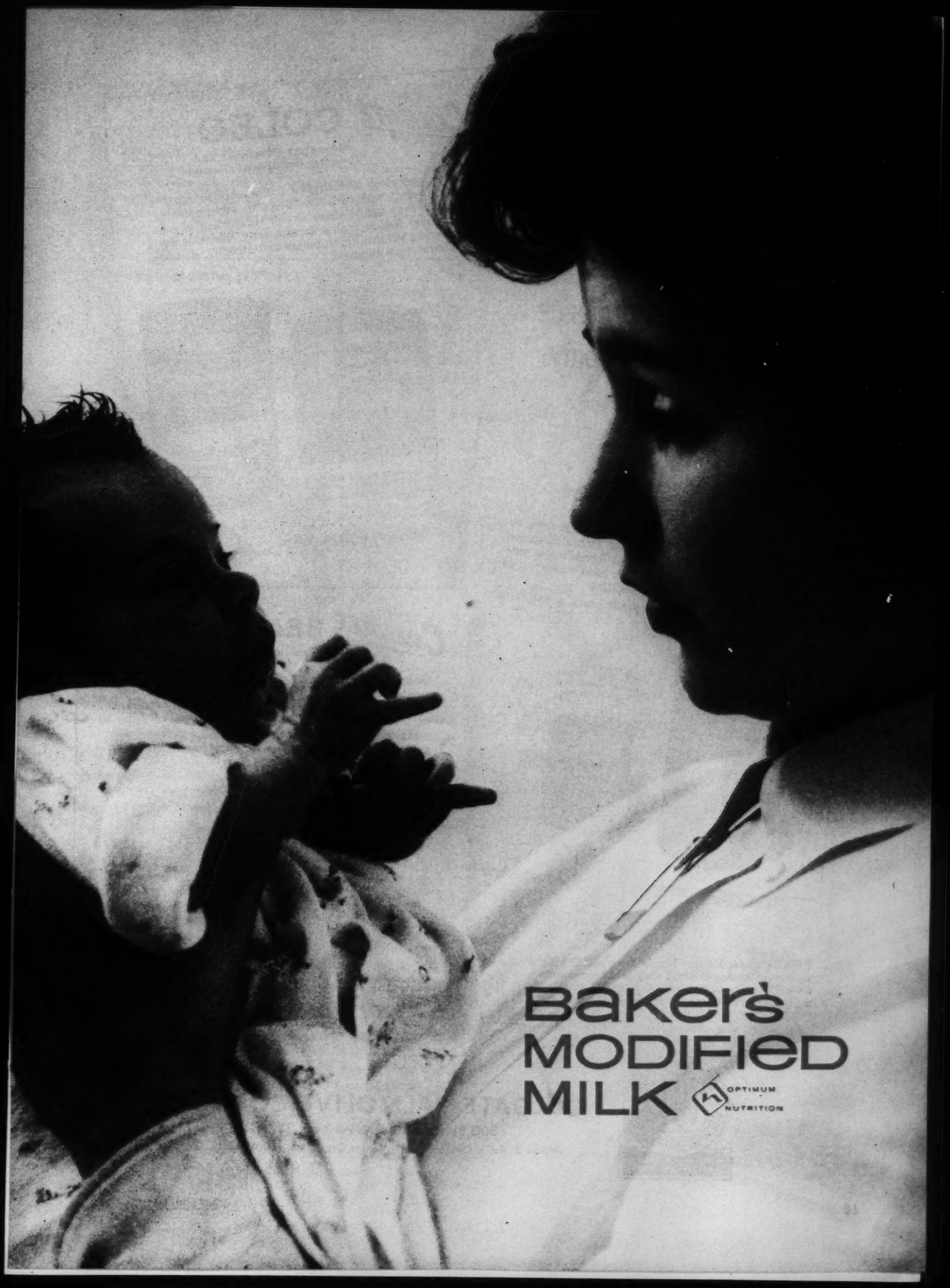
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equipment and supply review

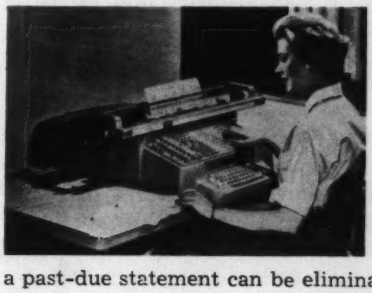
New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association. See coupon page 74.

Cool-vapor machine (15D-1)

Manufacturer's description: This unit provides convenient, direct administration of cool-vapor therapy at the airway in croup, asthma, bronchitis and other respiratory disorders without masks, tents or canopies. Cool, moisture-laden fog also relieves intubation irritation and postoperative dehydration of the respiratory tract. This unit consists of an adjustable, counter-poised arm and vapor delivery head mounted on a metal utility table, plus a portable compressor-aspirator, and a filter to remove all air contaminants down to 0.5 micron in size and provide a safe supply of compressed air to operate the unit. The cool-vapor arm may be adjusted by the patient himself, thus saving valuable nursing time. *Air-Shields, Inc., Dept. H13, Hatboro, Pa.*

Accounting machine (15D-2)

Manufacturer's description: Accounting machine has electrically controlled mechanisms for determining and initiating the proper posting program. The need for an operator to compare a patient's balance and payments to determine whether he should be mailed a past-due statement can be eliminated. The machine also can automatically decide that an inventory item should be replenished. It can automatically verify the accuracy of balance pickups, clear pickup errors, and reposition the carriage for making the pickups again. It provides automatic totaling, subtotaling, and repeat or date printing, as the carriage moves in either forward or reverse direction. The machine also has the ability to record data automatically in either punched paper tape or punched card form. *The Na-*



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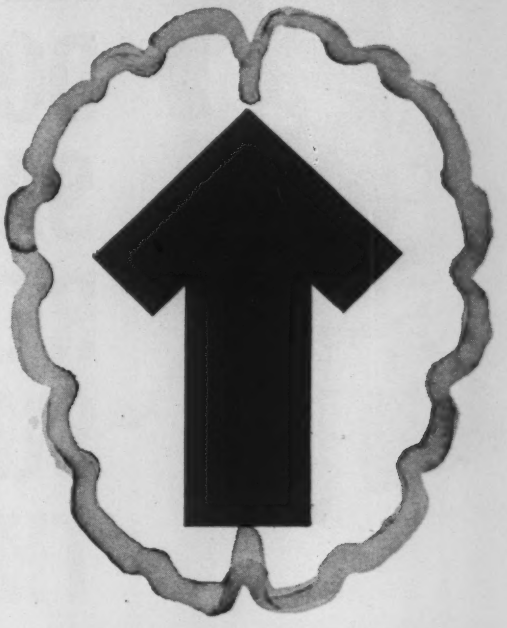
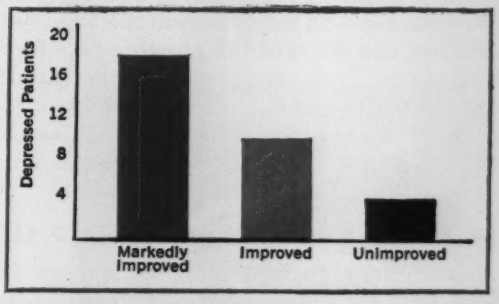


Revitalizes depressed patients—elevates mood, increases alertness and ability to maintain work and social adjustment.[1,2]



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2. Agin, H. V.: Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958.

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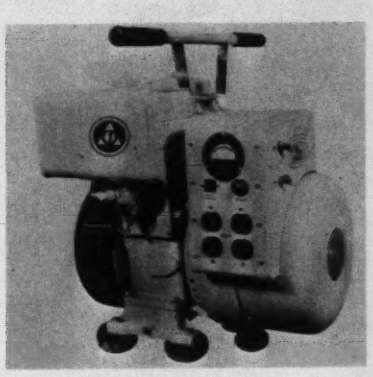
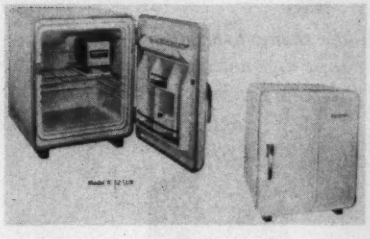
tional Cash Register Company, Dept. H13, Dayton 9, Ohio.

Emergency electric plants (15D-3)
Manufacturer's description: These new emergency electric plants range in size from one through 15 kw. All units exceed civil defense specifications. Added features are total output terminals; engineering permitting operation at full-rated capacity at elevations up to 5000 ft.; radio shielding; fungicide protective coating; electric start and remote control; four-cycle engines on all units; and special instrumentation enabling anyone to operate the units. The instrument panel is reflection-proof and tilted at a 45° angle for easy reading. The only maintenance involved is adding gasoline and oil. *Pacific Mercury, Dept. H12, 14052 Burbank Blvd., Van Nuys, Calif.*



Portable refrigerator (15D-4)
Manufacturer's description: Portable electric refrigerator works on the absorption principle without a motor. It features noiseless operation, automatic thermostatic action and performance on direct or alternating current. It has a storage compartment in the door, a large capacity ice cube tray, adjustable shelves and a plastic drip-pan. The all-steel cabinet with baked enamel finish is fully insulated. There is a five-year warranty on the cooling unit and a one-year warranty on all other parts. *Andrikian Trading Co., Dept. H13, 401 Broadway, New York 13.*



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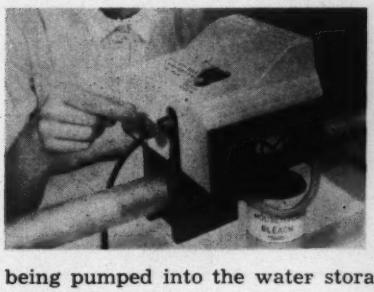
Manufacturer's description: Electrically operated, positive feed chlorinating unit can treat up to 75,000 gallons of water daily. The unit is controlled by an electrical circuit similar to that used to operate the water pump in a private well. It operates only when water is being pumped into the water storage tank to main-



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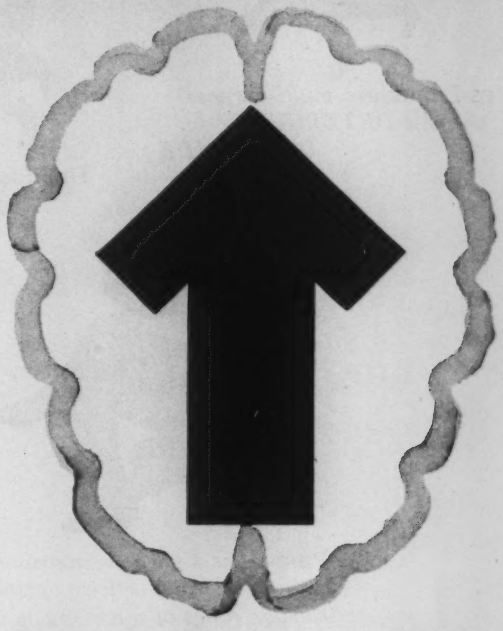

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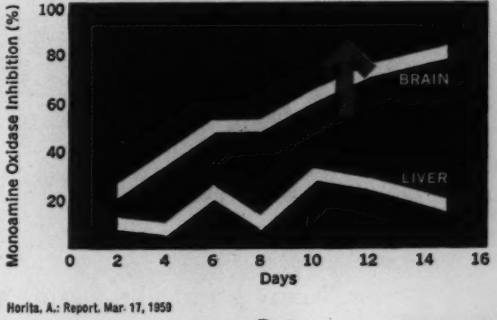

Horita, A.: Report. Mar. 17, 1959

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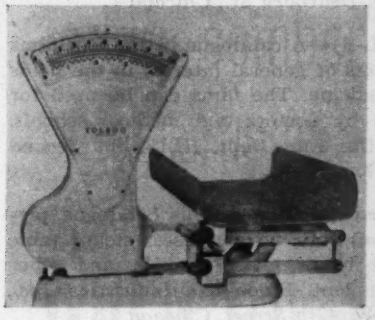
tain the desired pressure. The unit injects a tiny stream of ordinary household bleach into the water supply in the exact proportion needed. The rate of feed is adjusted by a finger tip control knob. *Clayton Mark & Co., Dept. H13, 1900 Dempster St., Evanston, Ill.*

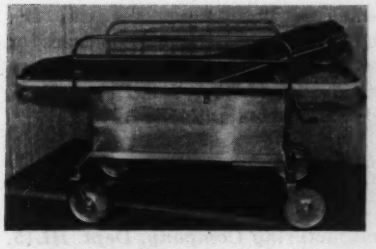
Baby weighing scale (15D-6)

Manufacturer's description: New baby weighing scale features a combination avoirdupois and metric equivalent chart. Avoirdupois weights are to 10 lbs. in 1 oz. graduations. Metric equivalents are to 4½ kg. by 20-gram graduations. A 10-lb. 1-oz. tare beam is provided to offset the weight of blankets or other protective covering. The scale is equipped with an acrylic plastic platter with 4-in. vertical side guards and is finished in a gleaming white baked enamel to meet sanitary standards. *Toledo Scale, Division of Toledo Scale Corporation, Dept. H12, Toledo 12, Ohio.*



New wheeled stretcher (15D-7)

Manufacturer's description: This new wheeled stretcher features a hydraulic pedal lift that enables nurse or attendant to easily raise or lower the stretcher while standing in one position. The stretcher top measures 26 by 74 in. and has complete provision for all accessories. The stretcher extends 10 in. over bed on either side. A one-pedal floor lock adds to its safety. Pushbutton release permits hinged siderails to be put quickly into position by pulling the rail at any point. The stretcher is finished in stainless steel and in chrome plating. *Tabbert Bros. Mfg. Co., Dept. H12, Bridgman, Mich.*



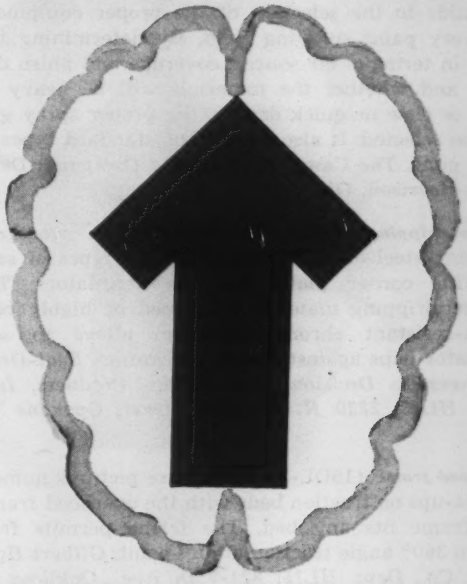
Mop head (15D-8)

Manufacturer's description: Mop head is made of nylon yarn in a webbed, controlled-pattern design with a control band stitched to the yarn. The yarn is said to absorb more than twice as much moisture as conventional cotton mops.

new psychoactive agent

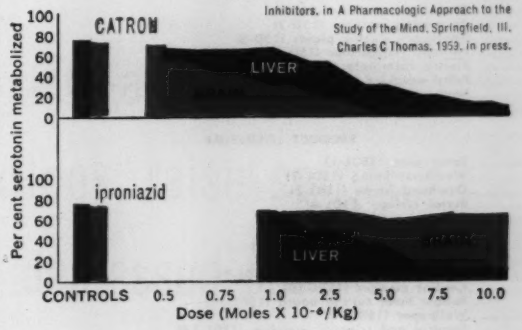
Catron®

β-phenylisopropyl hydrazine supplied as the hydrochloride



Elevates mood, brightens outlook by raising levels of mood-controlling neurohormones, serotonin and norepinephrine . . . at doses which have little or no effect on the liver.

Horita, A.: The Pharmacology of the Monoamine Oxidase Inhibitors, in A Pharmacologic Approach to the Study of the Mind. Springfield, Ill. Charles C Thomas, 1959, in press.



Lakeside Laboratories, Inc. Milwaukee 1, Wisconsin

54959-C

Mop heads can be washed in ordinary washing machines without tangling or tying the threads. The control band holds the yarn firmly in a mopping pattern; prevents tangling, raveling, or wrapping around the mop handle or furniture, and prevents lint deposits on floors or in drains. *South Eastern Cordage Co., Dept. H13, 815 Superior Ave., Cleveland 14.*

product literature

Spray guns (15DL-1)—Bulletin features an easy-to-use guide to the selection of the proper equipment for every paint spraying need. By determining the usage in terms of air source, coverage and finish desired, and whether the materials will be heavy or light, or slow or quick drying, the proper spray gun may be selected. It also defines the standard types of spray guns. *The Campbell-Hausfeld Company, Dept. HL15, Harrison, Ohio.*

Weatherstripping (15DL-2)—Material on weatherstripping steel or aluminum projected types of sash featuring corner plates for the ventilators. The weatherstripping material is formed of highly corrosion-resistant chrome-aluminum alloys to seal ventilator gaps against excess infiltration. *Seal-Draft Weatherstrip Division, Sun Screen Products, Inc., Dept. HL15, 2220 N. Division Street, Spokane 21, Wash.*

Overhead frame (15DL-3)—Brochure pictures numerous set-ups on traction beds with the overhead frame. The frame fits any bed. The frame permits from zero to 360° angle traction at any point. *Gilbert Hyde Chick Co., Dept. HL15, 821-75th Ave., Oakland 21, Calif.*

If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

- ____ Cool-vapor machine (15D-1)
- ____ Accounting machine (15D-2)
- ____ Emergency electric plants (15D-3)
- ____ Portable refrigerator (15D-4)
- ____ Electric chlorinator (15D-5)
- ____ Baby weighing scale (15D-6)
- ____ New wheeled stretcher (15D-7)
- ____ Mop head (15D-8)

PRODUCT LITERATURE

- ____ Spray guns (15DL-1)
- ____ Weatherstripping (15DL-2)
- ____ Overhead frame (15DL-3)
- ____ Rectal syringe (15DL-4)
- ____ Cleaning methods (15DL-5)
- ____ Medical films (15DL-6)
- ____ Food service products (15DL-7)
- ____ Hospital booklet (15DL-8)
- ____ Change-making equipment (15DL-9)
- ____ Cardiac monitor (15DL-10)
- ____ Rubber meat cutting board (15DL-11)
- ____ Wallpaper (15DL-12)
- ____ Surgical and scientific supplies (15DL-13)

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

(Please type or print in pencil)

Rectal syringe (15DL-4)—Booklet describes an improved disposable plastic syringe for rectal administration of Pentothal sodium suspension. *Abbott Laboratories, Dept. HL15, North Chicago, Ill.*

Cleaning methods (15DL-5)—Bulletin board poster "H" uses the cartoon approach to the proper techniques of mopping floors and choosing correct cleaning solutions. The poster also offers many helpful safety hints. *National Sanitary Supply Association, Dept. HL15, 159 N. Dearborn St., Chicago 1.*

Medical films (15DL-6)—A catalogue listing free films which cover subjects of general interest in the fields of science and medicine. The films can be used for teaching purposes by doctors and medical schools. *Chas. Pfizer and Co., Inc., Dept. HL15, 800 Second Ave., New York 17.*

Food service products (15DL-7)—This catalogue pictures and describes tote boxes, cases, steam table pans, steam table insets, pots, utensils, and other food service equipment. *Bloomfield Industries, Inc., Dept. HL15, 4546 W. 47th Street, Chicago 32.*

Hospital booklet (15DL-8)—A booklet, using a scriptographic technique, discusses the various hospital departments and types of equipment which have been developed to serve the public in recent years. It also explains where the hospital dollar goes and relates the average cost-per-day to the many different services provided. *Channing L. Bete Co., Inc., Dept. HL15, Greenfield, Mass.*

Change-making equipment (15DL-9)—This brochure describes change-making equipment, pictures the various models and lists prices. Numerous sizes of manual and fully automatic electric coin changers are available. *Standard Change Makers, Inc. Dept. HL15, 422 East New York Street, Indianapolis 2.*

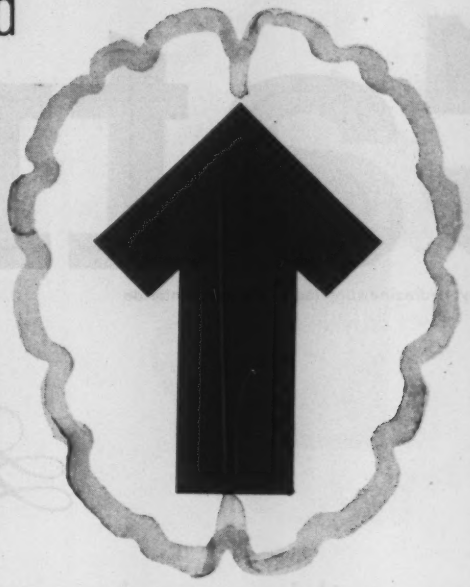
Cardiac monitor (15DL-10)—A cardiac monitor, with R-wave pick-up, pulse pick-up or combined pulse and R-wave pick-up, is described in detail in this booklet. *E & J Manufacturing Company, Dept. HL15, P.O. Box 710, Burbank, Calif.*

Rubber meat cutting board (15DL-11)—This bulletin pictures and describes a rubber meat cutting board which will not crack, split or chip out when used for all types of boning, chopping, slicing and dicing work. It is claimed that it will last longer than wood. *Park Rubber Co., Inc., Dept. HL15, Lake Zurich, Ill.*

Wallpaper (15DL-12)—Material describing a new decorative wallpaper of a nonwoven fabric, impregnated with vinyl, giving the rugged durability of plastic. The new wallpaper can be washed, is stain-resistant and crack-proof. *The Brige Company, Dept. HL15, 390 Niagara Street, Buffalo.*

Surgical and scientific supplies (15DL-13)—This catalogue lists and illustrates in detail 1200 products for laboratory, hospital, and doctor's office. The products are divided into seven main categories, arranged alphabetically and numerically. *Clay-Adams, Inc., Dept. HL15, 141 East 25th St., New York 10.*

withdrawn apathetic rejected gloomy
remorseful hopeless listless despairing
forlorn somber defeated
bitter crushed



WHEN THE WORDS
MEAN DEPRESSION,
THE TREATMENT IS

Catron®

β-phenylisopropyl hydrazine supplied as the hydrochloride

Important new psychoactive agent—acts selectively on the brain to brighten outlook, raise spirits, rebuild self-esteem, revitalize depressed patients.

Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin

For detailed information, request Brochure No. 19, CATRON

56559-D

Important New

Catron®

β-phenylisopropyl hydrazine supplied as the hydrochloride

Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin

How to use this new drug:

CATRON Hydrochloride is a monoamine oxidase (MAO) inhibitor useful in the treatment of depression and of other disorders indicated below. It is recommended for use in carefully selected cases and in those patients who have not responded to the milder drugs.

ADMINISTRATION AND DOSAGE

Dosage of CATRON must be individualized according to each patient's response. The initial daily dose should not exceed 12 mg. and should be reduced as soon as the desired clinical effect is obtained. In severe depressions some clinicians desire rapid results and begin treatment with 24 mg. daily: this dosage should not be continued for more than a few days. A single daily dose in the morning is recommended. A continuous or interrupted schedule may be used, the latter during the maintenance period.

DEPRESSION (Endogenous, Reactive, Postpartum, Involutional and Depression Secondary to Schizophrenic or Neurotic Reaction): initially, 12 mg. once daily for approximately 2 weeks, or less if improvement appears. Dosage is then reduced to 6 mg. daily. As improvement continues, maintenance dosage of 6 mg. every other day or of 3 mg. daily often proves satisfactory. An interrupted dose schedule is recommended for long-term therapy.

ANGINA PECTORIS—3 to 6 mg. daily in most cases. Relief of pain and elevation of mood may be dramatic. Victims of angina pectoris who respond in this manner should be cautioned against overexertion induced by their sense of well-being.

RHEUMATOID ARTHRITIS (Adjunctive Therapy—in severely disabling forms, particularly when accompanied by depression): 9 to 12 mg. daily for 3 days, then 6 mg. daily, reducing further to 3 mg. daily on signs of improvement. If a conventional antiarthritic agent is used, lower doses of each are indicated.

CAUTION

Certain circumstances should be watched carefully when using CATRON.

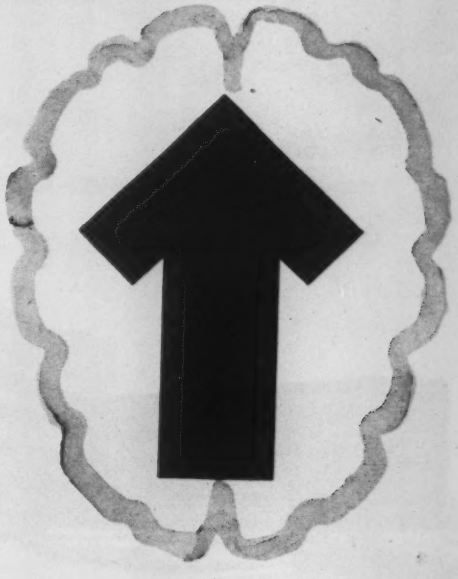
DRUG POTENTIATION—The list of drugs which CATRON potentiates is not yet complete. CATRON should not be used concomitantly with any other drug unless, (a) it has been ascertained that the two drugs bear no qualitative relationship, or (b) potentiating action is being sought, as may be the case with tranquilizing drugs including reserpine and the phenothiazines, and with the amphetamines, barbiturates and hypotensive agents.

HYPOTENSIVE EFFECT—All normotensive patients receiving CATRON, but especially elderly patients, should be warned about the possibility of orthostatic hypotension during the initial period of higher dosage. In the few instances where this may occur, lowering of the dose will usually permit continuation of therapy.

COLOR VISION—A reversible red-green color defect has been reported in a few patients, chiefly hypertensives, on ex-

Psychoactive Agent

- Brightens mood, diminishes apathy and confusion, curbs symptoms of withdrawal, self-pity, inadequacy, despair.[1,2]
- Acts selectively on brain at doses having little or no effect on liver.[5-7]
- Valuable in depressions associated with chronic diseases such as angina pectoris,[8] severe rheumatoid arthritis.[9]



For detailed information, request Brochure No. 19, CATRON

tended therapy with CATRON. Discontinue the drug if such changes occur.

ANIMALS, NEUROLOGIC SIGNS—In toxicity studies with animals, a neurologic syndrome has been observed characterized by tremors, muscle rigidity and difficulty in locomotion. Although extensive clinical experience has not shown such reactions to be a problem in humans in recommended dosage, should a similar neurologic disturbance occur, the possibility of drug action should be considered.

SIDE EFFECTS—Major side effects requiring cessation of therapy are infrequent. Other side effects—constipation, delay in starting micturition, increased sweating, hyperreflexia, ankle edema, blurring of vision, dryness of the mouth—are usually readily controlled by lowering the dosage. Rash, observed in a few patients, cleared up rapidly upon discontinuing therapy.

WARNING: Pharmacologic studies show that with proper dosage CATRON will inhibit monoamine oxidase in the brain without influencing this enzyme in the liver. This is in contrast to previous inhibitors, which depress monoamine oxidase activity in the liver before affecting this enzyme in the brain.

Although the evidence suggests that serious life-threatening hepatitis seen with other MAO inhibitors should not occur with CATRON in the recommended dosage, it has been reported on rare occasion with dosages in excess of the recommended levels.

The Following Precautions are Recommended:

1. In all instances daily dose should not exceed 12 mg.
2. Reduce daily dose as soon as response is established, usually in a matter of 1 to 2 weeks.
3. Do not prescribe to a patient more than sixteen 6 mg. tablets or thirty-two 3 mg. tablets of CATRON at one time.
4. Patient should return for observation before additional CATRON is prescribed. For this reason, prescriptions for CATRON should be marked, "not refillable."
5. Perform regular liver function tests.
6. Do not use the drug in patients with a history of viral hepatitis or other liver abnormalities.

CATRON is the original brand of β-phenylisopropyl hydrazine. It is supplied as the hydrochloride in tablets of 3 mg. and 6 mg., bottles of 50.

(1) Agin, H. V.: The Use of JB-516 (CATRON) in Psychiatry, Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958. (2) Bercel, N. A.: A Pharmacologic Approach to the Study of the Mind, Springfield, Ill., Charles C Thomas, 1959, in press. (3) Kinross-Wright, J.: Panel Discussion of Psychic Energizers, *ibid.* (4) Kinross-Wright, J.: Experience with JB-516 (CATRON) and Other Psychochemicals in Clinical Practice, Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958. (5) Horita, A., and Parker, R. G.: Comparison of Monoamine Oxidase Inhibitory Effects of Iproniazid and Its Phenyl Congener, Proc. Soc. Exper. Biol. & Med. **99**:617, 1958. (6) Horita, A.: *Beta*-Phenylisopropylhydrazine, A Monoamine Oxidase Inhibitor, Fed. Proc. **17**:379, 1958. (7) Horita, A.: The Pharmacology of the Monoamine Oxidase Inhibitors, in A Pharmacologic Approach to the Study of the Mind, Springfield, Ill., Charles C Thomas, 1959, in press. (8) Kennamer, R., and Prinzmetal, M.: Treatment of Angina Pectoris with CATRON (JB-516), Am. J. Cardiol. **3**:542, 1959. (9) Scherbel, A. L., and Harrison, J. W.: The Effects of Iproniazid and Some Other Amine Oxidase Inhibitors in Rheumatoid Arthritis, Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958.

B4559-E

Baptist Memorial Hospital, Jacksonville, Florida. Reynolds, Smith & Hills, architects and engineers, Jacksonville; Henry G. Dupree Co., general contractor, Jacksonville.

The modern way to control hospital air conditioning.

. . . JOHNSON PNEUMATIC CONTROL

Among the many modern features of the Baptist Memorial Hospital at Jacksonville, Florida, is a complete system of individual room temperature control. This gives *each room* the "weather" best suited to its purposes and occupants.

The Johnson Pneumatic Control System regulates the thermal environment throughout the entire hospital. Operating room conditions can be adjusted to the individual patient's needs. Nursery warmth can be kept constant. Delivery rooms, bedrooms, kitchens, corridors, lobby . . . all can be selectively controlled for heating or cooling.

Unhealthful, uncomfortable temperature variations are avoided and time-wasting temperature checking eliminated. Safety is assured in areas where anesthetic gases are in use.

A special feature of the system prevents the transmission of odors and airborne contaminants between rooms. This is done by maintaining a positive pressure in the corridors, so that air cannot flow out of the rooms and, thence, to other parts of the hospital.

Better care and comfort for patients follows. Staff efficiency is improved. Long range economies in heating and cooling are a major benefit.

For similar advantages when you build or air condition, be sure to include a Johnson Control System. Only a modern pneumatic system can meet the diversified temperature and humidity demands of a hospital so effectively, safely, and economically. Ask your consulting engineer, architect, or local Johnson branch about a system of pneumatic control for your requirements. Johnson Service Company, Milwaukee 1, Wisconsin. 105 Branch Offices.

JOHNSON CONTROL

PNEUMATIC SYSTEMS

DESIGN • MANUFACTURE • INSTALLATION • SINCE 1885

All about paint

- **Components and finishes**
- **New and special-use formulations**
- **Selection and application**

by STEPHEN L. WOLF

IN ORDER to understand why paint acts the way it does, why we use certain paints on certain surfaces and why paint sometimes fails, we must know something of the technical side of paint.

Paint has three components: pigment, vehicle and thinner. Pigment is the component which gives paint its color and some of its protective qualities. The major pigment in use today is titanium dioxide, a white pigment which is far superior in many ways to the old standard white lead. Some other pigments used primarily for color are the earth colors, such as raw sienna and raw umber, and the chemical colors, such as chrome green and chrome yellow.

Another kind of pigment is zinc chromate which we do not use for its color but for its protective qualities—in this instance, the quality of inhibiting rust. Sometimes the pigment is known as a

Stephen L. Wolf is president of S. Wolf's Sons, New York City.

A WORD ABOUT LABELS

There are several words found on paint can labels which may be termed "catchwords" because they can be ambiguous or misleading. These words all describe desirable qualities in a paint, and are used in the label as a sales incentive. But the degree to which these qualities exist in the paint in the can is likely to vary widely. The integrity of the paint manufacturer is the buyer's safeguard in evaluating the claims made on the label.

ALKYD—There are alkyds and alkyds—some top grade and others inferior. There may be very little alkyd, of either good or poor quality, in the paint formula, or it may be incorrectly blended with the other components.

PLASTIC—Most paints sold today may be called plastic paints because they are made with synthetic resins—an alkyd, a poly-vinyl, or an acrylic. Although plastic implies a thickness not possessed by a coat of paint, it is a term used persistently and often misleadingly.

FLAT ENAMEL—Formerly, an enamel paint was always a gloss finish, but, when the alkyd flat paints were developed, flat enamel was the term coined to indicate a flat finish with the washability (almost) of enamel.

WASHABLE—The washability of paint has two aspects: stain-resistance or porosity of finish and abrasion-resistance or hardness of finish. Enamels resist staining, but flats do not because they are more porous. Of the flat paints, latices are more stain-resistant than alkyds, and alkyds are more so than oil base paints. Today, there is no completely washable paint, although some of the modern formulations approach this ideal.

ONE-COAT PAINT—This is a relative term, capable of misuse, because the condition of the surface to be covered determines if it can be covered with one coat of paint. Bare plaster walls, for example, will require a prime coat, even if a one-coat paint is to be used. Today, the penetrating power of one-coat paints has been reduced, so that they tend to lie on the surface rather than to soak into it.

NONYELLOWING—No paint is 100 per cent nonyellowing, but modern paints are much superior in this respect to those of 15 to 20 years ago.

The hospital engineer who keeps these comments in mind will not be so apt to be misled by terminology when purchasing paint.

filler, or extender, pigment. This type of pigment is not used to cheapen the paint but rather is often a necessary part of the formulation, improving the performance and durability of the product.

TYPES OF PAINT VEHICLES

The second component of paint is the vehicle, or binder. This is the film-forming portion of the paint—that portion which dries, adheres to the undersurface and holds the pigment. Linseed oil was the prototype of the solvent-thinned vehicle, but today it has been replaced by synthetic resins. There are two distinct types of synthetic vehicles, the solvent-thinned and the water-thinned. Among the more important of the synthetics is alkyd resins. Alkyds possess a great many advantages. They do not darken or yellow with age so they can be used to make nonyellowing whites. They show good gloss retention and dry to an exceptionally hard film. They do not soak into the undersurface the way some oils do; therefore, one coat will do where two were required before. Other important synthetic resins are the phenolic, the maleic and, one of the newest and most interesting, the epoxy. In most formulations these resins are not used straight but are combined with oils, utilizing the properties of the several ingredients to form a highly complex vehicle.

The other type of synthetic vehicle, the water-thinned, is best illustrated by the latex group. Latex is a synthetic, rubber-like resin which has been emulsified so that it is water-soluble. It produces a paint which is easy to apply, fairly impervious to staining and highly washable. There are three major formulations of latex in use, styrene butadiene, polyvinyl acetate and acrylic.

TYPES OF PAINT THINNERS

The third component is the thinner—that material which makes it possible to brush or spray the paint. Without it the paint would be viscous and would not spread smoothly. The most widely used thinner in oil and resin paints is mineral spirits, a petroleum distillate. Much less expensive than turpentine, but with similar solvent properties, it has replaced turpentine in most formulations. Benzine, also used as a thinner, is a petroleum distillate too, but it evaporates faster than mineral spirits. Because of this characteristic, paint thinned with benzine cannot be brushed as easily as that thinned with mineral spirits. Odorless thinner, a relatively new product, is produced by treating mineral spirits to remove objectionable vapors. Some synthetic enamels are thinned with more powerful solvents, such as xylol. The emulsion paints, such as latex, are thinned with water.

STANDARD PAINT FINISHES

These are the elements of paint: pigment, vehicle and thinner. But how we combine them will make a vast difference in the paint products. Most important in this process is the ratio of pigment to the total volume of paint. Known to the chemist as pigment-volume concentration, this ratio determines whether a paint is a gloss, semigloss or flat. In gloss paint there is a greater volume of vehicle than pigment. Consequently, the vehicle completely submerges the pigment, forming a smooth, continuous, glossy surface. The smooth surface will shed dirt easily and will be highly washable.

In a flat paint, there is more pigment and less vehicle. As a result, the vehicle does not cover the pigment and the pigment actually sticks up through the vehicle. The surface is coarse and diffuses light, so it appears flat. Such a surface tends to hold dirt and to be difficult to clean. Today's washable flat paints have overcome this problem to a large extent. Both alkyd and latex films, even though flat, dry sufficiently hard to permit washing, but they do not have the washability of a gloss enamel.

In a semigloss paint there is not quite enough vehicle to cover the pigment. Semiglosses, of course, run the whole range from eggshell sheens to satin finishes, and controlling the exact degree of gloss is a matter of great precision.

In addition to the flat paints and enamels, there are a number of paints designed for specialized purposes. One of these is the multicolor paint, which is made up of tiny flecks of different colors. It is slightly textured, much thicker than the usual paint film and is unusually hard. Two main types of multicolor paint are a lacquer emulsion and a synthetic or latex. The lacquer emulsion is thinned with water and is very fast drying. Its main disadvantage, particularly for hospitals, is its lacquer odor. The synthetic or latex type has relatively little odor, but it does not dry as fast nor is it as hard. Multicolor is primarily a spray paint. It cannot be brushed, but it can be made in a roller formulation, although this gives a less satisfactory appearance than the spray.

The advantages of multicolor paint are its appearance, its hardness and washability, and its ability to hide surface defects. Another disadvantage is that, if a multicolor finish is repainted with a traditional paint, the texture will continue to appear. The major question to be answered is how well it will stand up as it is recoated over a period of years. Eventually there will be an extensive buildup of paint on the surface and this may become a problem.

FIRE-RETARDANT PAINTS

Improved fire-retardant paints are now available. Fire-retardant paints have been on the market for years but, although their fire-retardant properties were good, they were mediocre paints. However, it is now possible to formulate these products in many types of finishes and with all the characteristics of the finest materials. These paints swell, when heated, to form a spongy mass which keeps oxygen away from the substrata. The significance of this for hospitals cannot be overestimated.

Germ-proof paints are of particular moment to the hospital field, but to date there has been no conclusive evidence proving their value, so judgment must be withheld until further research is done.

RUST-RESISTANT PAINTS

Rust-resistant paint has been the subject of considerable controversy in the industry, but it may be helpful to give a run-down on the various products on the

market. The old reliable, of course, is red lead. Its primary use is on large iron and steel structural work. There is some question about its efficacy on rusted surfaces. World War II saw the development of zinc chromate primers. Zinc chromate reacts, as does red lead, with the metal to inhibit corrosion. It has been particularly effective with the lighter metals, such as aluminum. Zinc dust primers are still more recent, and are among the best primers for galvanized metal.

There is another type of rust-inhibitive primer which does its work through the vehicle rather than through the pigment. The vehicle, usually an alkyd, is formulated to impart excellent wetting properties to the paint. On surfaces which are partially rusted, this material penetrates the rust pits, replaces any moisture present and tends to retard the spread of the rust.

Neoprene and hypalon, two synthetic materials akin to rubber, are among the latest products. They do their work by forming a thick, impervious film over the surface of the metal. They have excellent water and chemical resistance.

THE PAINT SELECTION PROCESS

How does the hospital engineer get the most for his paint dollar with all these products available?

Selecting the type of paint for a specific job is the first consideration. Does he want a flat paint, a semigloss or an enamel? A latex or an alkyd?

What price paint should be used? It is never economy to buy cheap paint, but it is not always advisable to buy the most expensive. Even the finest paints will not stand up to certain types of abuse—the banging of a hospital cart, for example. For many areas, a good medium-priced paint is the proper product to purchase.

Once the type of paint has been selected, the engineer should choose the particular paint by specification or by brand name. In most instances, ordering by specification is impractical because asking a manufacturer to make up a specification material at an economical price would require ordering in larger quantities than is usually wise. Selecting paint by brand is the simpler method and is one way of insuring uniformity of product.

Should the engineer do paint-testing prior to buying? Periodic testing is advisable, provided allowance is made for a margin of error in the results. The important point about testing is to maintain uniform conditions of surface and application with each sample. Two tests should be made under different conditions with different painters on different days. If white enamels are to be tested, select a back stairway where samples can remain for six months or more. A painter can brush out panels, four or five feet square, of each enamel to be tested, thinning the enamel according to the manufacturer's direction and brushing out each panel in the same manner to get as even a film thickness as possible. On the following day, another painter can repeat this procedure in another area.

PAINT TEST RESULTS

What should be looked for? Ease of application, good flow without runs or sagging, good covering, low odor, and speed of drying. After 30 days, the panels should be checked for washability. Putting dirt, lipstick, and greases on the panels is useful for this test. After six months the panels should be checked for whiteness (the nonyellowing characteristic) and loss of gloss.

Observations must be made with care because tests such as these are unscientific and lack the controls required for precise evaluation. They are merely for guidance and will serve primarily to eliminate any exceptionally poor material.

CHOICE OF COLORS

After brand selection comes selection of color. This is frequently done by an architect or decorator on the hospital staff. However, it is often the engineer's job to match the color selected and this can be a problem. There are several possible solutions. If the painter is sufficiently skilled, he can usually mix his own colors.

A second solution is to restrict the choice of colors to those shown on the color card. Most manufacturers produce a fairly satisfactory range of 20 to 25 colors, but decorators and designers usually rebel at any such restriction. But, if the engineer is on his own, this is a good policy.

A third solution is to have the dealer mix the color. If a large quantity is involved, this can be done at the factory. If it is a matter of a few gallons, the dealer probably can come close within the limits of a color-mixing system. Specially mixed colors usually cost more than stock colors.

THREE PAINTING METHODS

The engineer must next decide on the method of paint application. In some instances, this will be determined by the type of paint—for example, multicolor, which must be sprayed. But the engineer usually will have a choice of brush, roller or spray methods.

Spraying is the fastest method of paint application, but only for extensive work. It is not worth setting up spray equipment, adjusting it and cleaning it for a small job. Since spraying puts paint into the air, all surfaces not to be painted must be adequately protected. When purchasing spray equipment, the engineer should be guided by his needs. If the equipment is to be used primarily to spray lacquer on furniture, a lightweight, inexpensive machine will do, but, if it is for spraying halls and stairways, it is poor economy to skimp on the equipment.

Brushing is, of course, the traditional means of applying paint. It is slow but sure, and may be used on almost any surface and under almost any condition. A good brush hand can probably do a better job with a brush than with any other method of application, particularly on critical surfaces.

There are also decisions to be made in the matter of brushes. The pure bristle brush is expensive. We have had success with mixtures of bristle and horsehair, and bristle and nylon, and more recently, with pure nylon. Nylon is relatively inexpensive, more durable than bristle and will turn out good work.

The third method of application is by roller, which has its advan-

tages. It involves no major investment for equipment, it is simple to use, and is fast. A mediocre painter will do a better job with a roller than with spray or brush. Rolling is primarily suitable for large, smooth areas, and is best with flat paints. With enamels it may leave a slight orange-peel stipple.

There are a number of roller styles available. For general use, a synthetic fiber that looks like cropped lambswool is highly suitable. There are also deeper piles, generally lambswool, for irregular surfaces such as cinderblock, and still heavier piles for cyclone fence.

SPECIALIZED USES OF PAINT

The composition of paint is a compromise in terms of its characteristics, and choice must be governed by specific need. If the paint is formulated to achieve extremely fast drying, there may be some sacrifice of film flexibility or ease of brushing. If the paint is intended to achieve one-coat covering, there may be some loss of adhesion. Oils and resins and pigments and thinners may be balanced to give a certain result, but in the process something else is lost. This is why today there is such a large variety of coatings—each with its purpose—and this is why we cannot say absolutely that one type of paint is better than another, but rather that one type of paint is better than another for a particular job. Paints are formulated for specialized purposes. For example, flat paint should not be used as a primer. A primer-sealer or an enamel undercoater should be used. There are differences between a finish flat and a primer. Few would use the primer as a finish coat, so why use the finish coat as a primer?

Remember to read the directions. They tell what the paint will and will not do, and how to apply it properly. And don't tamper with the paint. We all know the painter who adds a little oil or a little drier. There are times when this is indicated, but the paint as it comes out of the can is about as good as the chemists can make it. Adding things will often upset a delicately balanced formula.

LIMITATIONS OF PAINT

Remember paint is only paint. There are some things it will not do. A paint film is about one-thousandth of an inch thick. It is remarkable what such a thin film does, but do not expect it to bridge cracks, hold back water in a wall, or to bind up a peeling undersurface. Paint may, for a time, hide a multitude of structural defects but it is not in its nature to correct them.

The last point is the most important of all. The surface to be painted must be well prepared. This is the foundation of the paint job. Each kind of surface presents its own particular problem. Galvanized metal must be cleaned and etched, plaster walls must be sealed, linoleum floors must be free of wax, and spackled spots must not only be sealed, but must be textured to match the balance of the wall. Most paint failures can be traced to either improper surface preparation or the presence of moisture. ■

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personnel changes

● **John Francis Blend** has been appointed administrator of the Mobile (Ala.) General Hospital. He was formerly administrator of the Jackson County (Tenn.) General Hospital.

● **Orville N. Booth** has been appointed vice president and administrator of St. Francis Memorial Hospital, San Francisco. Mr. Booth has been administrator of the hospital for the past 12 years.

● **Harold William Conran, M.D.,** has been appointed superintendent of Western State Hospital, Hopkinsville, Ky. Dr. Conran, who has been director of professional services of the Kentucky Department of Mental Health, succeeds the late R. G. Blackwelder, M.D.

● **William H. Cruse** was appointed administrator of Sunrise Hospital, Las Vegas, which opened Dec. 15, 1958. For the past four years, Mr. Cruse was administrator of various southern California hospitals on a consulting basis. Prior to that he was with two Blue Cross plans—Michigan Hospital Service and Hospital Service of Southern California.

● **Glen W. Fausey** has been appointed administrator of Memorial Hospital of Warren, Mich. He was formerly a consultant, and from 1939 to 1958 served as director of the Edward W. Sparrow Hospital, Lansing, Mich. Mr. Fausey succeeds **Irving A. Taylor** who has been appointed a hospital advisor to Cambodia for the International Cooperation Administration.

● **Leon Felson** has been appointed administrator of Kansas City (Mo.) General Hospital Number 1. He was formerly assistant director of Menorah Medical Center, Kansas City, Mo.

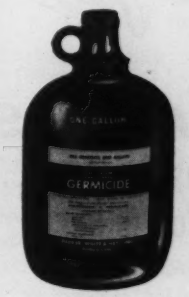
● **Lloyd L. Fray** has been appointed administrator of Caney Valley Hospital, Wharton, Texas, succeeding **E. H. Moore.**

● **Emory Giannangelo** (see Jackson item).

● **William D. Gibson** has been appointed administrator of Decatur County Memorial Hospital, Greensburg, Ind. He was formerly an administrative resident at Norfolk (Va.) General Hospital. Mr. Gibson is a graduate of the Medical College of Virginia program in hospital administration.

● **George R. Hart** has been appointed administrator of Scott County Hospital, Oneida, Tenn. He was formerly administrator of Habersham County Hospital, Demorest, Ga. Mr. Hart is a graduate of the Georgia State College course in hospital administration.

● **Mary L. Hemmy** has been appointed executive director of the Benjamin Rose Institute, Cleveland. Miss Hemmy was formerly professor of



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social casework in the School of Medicine and the Graduate School of Social Work at the University of Pittsburgh.

● **S. A. Jackson** has been appointed administrator of Lutheran Memorial Hospital, Grand Island, Nebr. He succeeds **Emory Giannangelo** who accepted a position at the Lutheran Hospital, Beatrice, Nebr.

● **Paul S. Jarett** has been appointed administrator of Burbank (Calif.) Hospital. He was formerly administrator of the West Valley Community Hospital, Encino, Calif. Mr. Jarett is a graduate of the State University of Iowa program in hospital administration.

● **Edwin R. Johns** has been appointed comptroller of New York Medical College, New York City. He was formerly assistant administrator of North Shore Hospital, Manhasset, Long Island, N.Y.

● **Richard G. Jones** has been appointed manager of the Veterans Administration Center, Hot Springs, S. Dak. He was formerly assistant manager of the VA Hospital, Palo Alto, Calif. Mr. Jones succeeds **Ray Q. Bumgarner** who has been appointed manager of the VA Center, Dayton, Ohio.

● **W. Boyd Jones** has been appointed administrator of Anniston (Ala.) Memorial Hospital. He was formerly administrator of Southeastern Kentucky Baptist Hospital, Corbin.

● **Robert L. Kidd** has been appointed administrator of Southeastern Kentucky Baptist Hospital, Corbin. He was formerly administrator of Hardin County General Hospital, Savannah, Tenn.

● **Robert Raymond Knowles, M.D.,** has been appointed superintendent of Kentucky State Hospital, Danville, succeeding **Leslie Wright, M.D.,** who has accepted a position in Missouri. Dr. Knowles has been clinical director of the hospital since 1956.

● **James E. McNelley** has been appointed administrator of the Memorial Hospital of Glendale, Calif. He was formerly administrator of the Beverly Community Hospital, Montebello, Calif.

● **Myron M. Millett** has been appointed administrator of Mendota (Ill.) Community Hospital.

● **John E. Milton** has been appointed assistant director of Presbyterian-St. Luke's Hospital, Chicago. He was formerly administrator of Edward Hospital, Naperville, Ill. Mr. Milton is a graduate of the Northwestern University program in hospital administration.

● **E. H. Moore** (see Fray item).

● **Leonard R. Piccoli** has been appointed assistant administrator of Misericordia Hospital, Bronx, N.Y. He was formerly administrative assistant at Montefiore Hospital in the Bronx.

● **William M. Pierce** has been appointed assistant administrator of St. Anthony Hospital, Louisville, Ky. He was formerly assistant administrator of Jewish Hospital in Louisville.

● **Irving A. Taylor** (see Fausey item)

● **Leslie Wright, M.D.** (see Knowles item)

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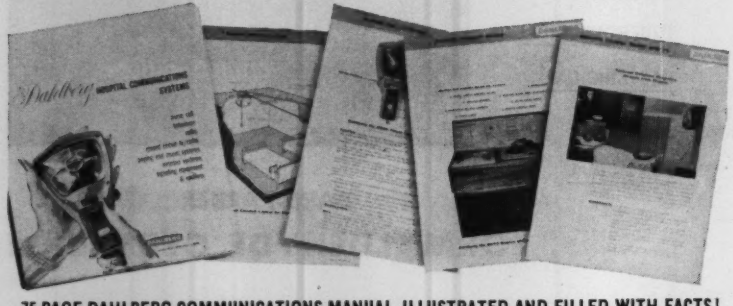

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book reviews

Planning psychiatric facilities

also:
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Supplement on maintenance

PSYCHIATRIC ARCHITECTURE. Charles E. Goshen, editor. Washington, American Psychiatric Association, 1959. 156 pp. $10.

Most American mental hospitals are human warehouses which our enlightened psychiatrists of 1850 would not have tolerated and which our European contemporaries have long since discarded in favor of more dignified and stimulating patient environments. How America came to accept this degrading standard and what psychiatrists and architects must do to overcome it are the twin themes of *Psychiatric Architecture.*

A large part of the material in the book is reprinted from papers or speeches previously reported in the journal, *Mental Hospitals,* by participants in the architectural study project of the American Psychiatric Association and the American Institute of Architects, supported by the Rockefeller Foundation, the Division Fund, and the U.S. Public Health Service from 1953 to 1958. As such, it is an authoritative account of our failure to recognize the impetus creative planning can bring to the resocialization of thousands of mental hospital patients who have withdrawn from social reality. It makes embarrassingly clear our ignorance of the advances which have been made in the last 30 years in Great Britain, the Netherlands, and Scandinavia, and provides guides for psychiatrists and architects to follow in regaining a constructive approach to planning.

Unfortunately, no series of unedited reprints can have the continuity, the even quality of writing, or the forcefulness of a single author. In this case, the deficiencies are emphasized by poor reproduction of both text and illustrations. An archaic glossary of architectural terms, apparently borrowed from an 1890 builders' handbook and included for the enlightenment of pyschiatrists, is more nostalgic than useful. Nevertheless, until a more cohesive account of the Architectural Study Project supersedes it, *Psychiatric Architecture* belongs on the reading list of everyone concerned with the programing or planning of psychiatric facilities.—JAMES J. SOUDER, *A.I.A., Director, Project W-59-Collaborative Research in Hospital Planning.*

Cost of medical care

THE MEDICAL CARE PRICE INDEX. Harry I. Greenfield and Odin W. Anderson. New York, Health Information Foundation, 1959. 22 pp. no charge (Research series No. 7)

This pamphlet is an excellent introduction to a very difficult subject and should be recommended reading for anyone concerned with health economics. With so much weight given to index numbers and the publicity that the medical care component receives, we need to know a great deal more about the advantages and limitations of the Consumer Price Index and its components in order to properly analyze and explain medical costs.

The report discusses the general theory of index numbers, the history and construction of the Consumer Price Index and the medical care component, as well as their validity, uses and limitations.

One of the basic problems of hospital economics is pointed up in the graphic presentations of the report. Scientific advancements in the production of commodities and the performance of many services have tended to reduce the amount of labor and materials required, thereby offsetting in part the increases in these basic cost elements. In hospital care, however, we have the opposite effect of scientific progress—more equipment, more materials costs, and greatly increased labor required to produce a day of patient care, which is the unit priced.—WILLIAM R. NIGHTINGALE, *manager, Research and Technical Assistance Division, Blue Cross Commission.*

Supplement on maintenance

PREVENTIVE MAINTENANCE GUIDE. American Hospital Association. Chicago, the Association, 1959. 82 pp. $2.

Planned maintenance is the key to a successful *preventive* maintenance program, with such planning coming from the administrator. It then becomes preventive maintenance when properly carried out by the hospital engineer.

This is the thesis of this small but complete manual which was developed by the Committee on Engineering and Maintenance of the American Hospital Association.

Pointing out that the American public has invested $12 billion in its hospitals, the manual offers expert guidance to administrators who are responsible for the protection of this huge investment. As the foreword indicates, the manual is intended to supplement the *Manual of Hospital Maintenance* of the American Hospital Association as a reference guide for administrators and as a handbook for hospital engineers.

The reader will find specific information as to how to prepare and operate an effective preventive maintenance program. Suggested procedures and forms are included which lend themselves to adaptation to any individual hospital's needs. Noteworthy is the comprehensive index and bibliography.

This manual will be a valuable tool for the administrator who needs to be convinced of the value of a preventive maintenance program and for the administrator who already is dedicated to the proposition that such a program protects not only buildings but also lives.—PAUL W. KEMPE, *Administrator, Silver Cross Hospital, Joliet, Ill.*

CANNED cling peach halves are filled with ham salad and chicken salad, and with cottage cheese to give novel appetite appeal for patients at luncheon or supper. Finger or open-faced sandwiches are attractive salad accompaniments.

THE GOLDEN TOUCH

-how to brighten hospital menus with canned peaches

FRUITS, WITH all their wide variety of colors, textures, and flavors, can be at home on any section of the menu—the three standard meals and in-between snacks besides.

Peaches, one of the most versatile of fruits, are even more adaptable because of the many forms in which they are available: fresh, canned or frozen; whole, halved or sliced; spiced, unsweetened, and so on. For institutional use, canned cling peaches have many advantages and applications. For breakfast the sliced peach makes a tasty garnish for cooked and ready-to-eat cereals. Canned peaches can be served with French toast or hot cakes, in which case the syrup may be gently thickened and spiced.

Cling peach halves are good served hot, with or without cream. The fruit is merely heated in its own syrup; a simple operation requiring no special talent.

PEACHY SALADS

Peach salads are legion. Canned cling peach halves filled with chicken, ham or turkey salad, with Waldorf salad, with grated raw carrots and raisins are just a few of the possibilities (see photo above). Cling peach slices combined with tart grapefruit segments, crisp unpeeled red apple, almond-stuffed dates or prunes are equally enjoyable. Tiny bits of candied ginger add piquantness to any canned peach preparation. Canned fruit cocktail with its interesting variety of fruits—peaches, pineapple, grapes, pears and cherries—has excellent salad and appetizer qualities, too.

A notable peach-vegetable combination features raw shredded cabbage, with well-drained, diced, canned cling peaches. A sour cream dressing makes it an all around, popular salad. Here is the recipe for 24 servings of peach slaw with sour cream dressing:

PEACH SLAW
WITH SOUR CREAM DRESSING
(24 servings)

- **2 (No. 2½) cans cling peach slices**
- **4 qts. cabbage, finely shredded**
- **½ pt. (1 c.) commercial sour cream**
- **2 tsp. celery seed**
- **2 tsp. prepared mustard (mild)**
- **1½ tsp. seasoned salt**
- **2 tsp. sugar**

1. Drain peaches thoroughly.
2. Turn cabbage into large bowl.
3. Combine sour cream with celery seed, mustard, salt and sugar. Add dressing to cabbage and toss lightly until well blended.
4. Add drained peach slices, mixing in gently.

Peach garnishes are popular, too. The cling peach half is a good sandwich, salad or cold platter accompaniment just as it comes from the can. Broiled cling peach halves are superb with entrees, such as oven-browned chicken (see p. 89). Cling peach halves dotted with butter, catsup, brown sugar or honey vie for first place among broiler offerings. Cling peach

This material was prepared by Ilma Lucas Dolan, dietitian, California Foods Research Institute, San Francisco.

SIMPLE SHOWMANSHIP IDEAS

WITH KRAFT PCs

More and more examples of how food service operators get a showmanship bonus from Kraft PCs are coming to my attention. A cafeteria reports that PC dressings displayed at the salad counter stimulate sales . . . A hotel coffee shop makes a big hit by giving customers a choice of PC jams and jellies in a tray . . . Using Kraft PC ice cream toppings, a Chicago restaurant features self-service sundaes.

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YOUR PC CHECK-LIST

Jams and Jellies	Apple, Mint-flavored Apple, Grape, Currant, Strawberry, Black Raspberry, Orange Marmalade, Cranberry Sauce
Condiments	Mustard, Ketchup
Dressings	French, Miracle Whip Salad Dressing, Mayonnaise, Tartar Sauce
Toppings	Caramel, Chocolate, Strawberry
Syrups	Maple-Flavored Syrup, Honey
20 PCs per tray	10 trays to a carton (Syrup is 5 trays per ctn.)

successful ideas for selling more . . .

DESSERTS

Last on the menu, desserts are first in profits when made with Kraft's *new* Flavored Gelatins, Puddings and Pie Fillings.

Gelatin cubes, like sparkling colored crystals, make attractive yet very economical desserts. Lemon Meringue Pie and Chocolate Pudding are equally good sales-clinchers.

Kraft Kitchen Reporter

Kraft's new gelatins are refreshingly like the natural fruit! They excel, not only in flavor, however, but in all the other qualities you need.

Actually, this *is* your formula! It was specifically developed to meet the exacting requirement of volume feeding. That's why these new Kraft gelatins give such exceptional results for every gelatin recipe.

They dissolve quickly, set fast and stand up well for remarkably long periods. The colors are clear, bright and natural, producing desserts (or salads) of sparkling clarity. Your customers will enjoy the delightful aroma, tender texture and delicious, ripe-fruit taste.

For your convenience, Kraft gelatins come in a new-type easy-to-open package, same color as the flavors: Strawberry • Lime • Cherry • Lemon • Raspberry • Orange • 1½ and 4½ lb. pkgs.

New Kraft Pie Fillings and Puddings

These new Kraft dessert products are excellent and versatile. Preparation is simple . . . Little time or labor is required . . . cost is low. This, plus the fact that you can make so many popular desserts from them, is a good omen for your profits.

Keep all four Kraft Pie Fillings and Puddings—Chocolate, Vanilla, Lemon, Butterscotch—on your dessert-pantry shelves. 1½ and 5 lb. pkgs. Lemon—1⅝ and 5 lb. pkgs.

Kraft quality from your kitchen brings customers to your tables

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halves filled with mincemeat, or mayonnaise seasoned with instant minced onion, and baked, are delectable, too.

DESSERT SURPRISES

Tempting desserts are colorful desserts and peaches can play an outstanding part. Take for example, peach Valentine meringues featuring the canned peach and frozen strawberry in a meringue form of your choice. Here is the recipe for this elegant but simply prepared dessert surprise:

PEACH VALENTINE MERINGUES

(30 servings)

3 boxes meringue mix (4.1-ounce box)
3 lbs. frozen sliced strawberries
30 large canned cling peach halves

1. Prepare meringue mix for shells, following package directions.
2. Cover baking sheets with heavy brown paper. To shape meringue shells, trace hearts approximately 3½ in. wide and 4 in. long on brown paper, spacing hearts 2 to 3 inches apart.
3. Fill pastry bag, fitted with No. 3 rosette tip, with meringue mixture. Outline heart with meringue; then work back and forth to fill in center; build up outside rim with 2 more layers of meringue.
4. Bake in a very slow oven (275° F.) for 1 hour.
5. Cool.
6. Partially thaw strawberries; drain peach halves.
7. Arrange meringue shells on serving plates; top each with peach half and spoon over partially thawed strawberries, using approximately 2 tablespoons for each serving.

Cling peach cobblers, sundaes, puddings, upside-down cakes never disappoint doubtful appetites. Peach frozen desserts and compotes are palate pleasers. Peaches poached in California sherry or port wine are also sophisticates in the dessert category.

When color, good looks and good taste are of primary concern, preparations with canned cling peaches can help solve the problems to everyone's satisfaction. These preparations are made even easier by the simplified and unified packs of canned cling peaches available to the institutional market. There are

BUTTER and honey broiled canned cling peach halves give appetite appeal and good flavor to richly browned chicken, hot biscuits and cream gravy. This dinner plate is designed to please the most fastidious patient.

the familiar grades: fancy, choice and standard. For the convenience of institutional users, there are several syrups or canning media from which to select:

1. Extra heavy syrup or extra heavy peach juice syrup.
2. Heavy syrup or heavy peach juice syrup.
3. Light syrup or light peach juice syrup.
4. Slightly sweetened water or slightly sweetened peach juice.
5. Water alone.
6. Peach juice alone.

While there are actually six types of containers in which the

PEACH Valentine meringue is an elegant dessert, yet not overwhelmingly complicated to prepare. Meringues—heart-shaped or otherwise—are made from the new mix, and the filling consists of a well drained canned cling peach half, accented with partially-thawed frozen strawberries.

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• Five more high-quality Heinz condiments you'll want to serve—Mustard, *new* Heinz Mustard Sauce, famous 57 Sauce, Worcestershire Sauce, Savory Sauce.

fruit is packed, for all practical purposes, the hospital dietitian is interested in the No. 2½ can or glass jar and the No. 10 can. Portion control becomes a simple matter with the information included in the chart below. ■

Approximate Net Weight, Contents and Servings for No. 2½ and No. 10 cans of Canned Cling Peaches.

CONTAINER	APPROX. NET WT.	APPROX. CONTENT (in cups)	APPROX. SERVINGS (1-2 halves, ½-cup slices)
No. 2½ can or glass jar	1 lb. 13 oz.	3½ c.	Serves 6-7
No. 10	6 lbs. 12 oz.	12 c.	Serves 25

Here are three recipes from Memorial Center

Turkey tetrazzini, baked eggplant and pecan pie have one thing in common—they are popular menu items with patients at Memorial Center for Cancer and Allied Diseases in New York City. In reporting this fact, Elma Frazer Perry, former chief dietitian at the hospital, also included the recipes here and featured these menu items in her set of fall cycle menus for the East beginning on p. 96.

TURKEY TETRAZZINI
(25, six-ounce portions)

- **1 lb. 12 oz. turkey, cooked and diced**
- **2 qts. turkey stock**
- **12 oz. mushrooms, sliced**
- **¾ c. onions, chopped**
- **1 tbsp. garlic salt**
- **1¼ c. turkey fat or margarine**
- **1¾ c. flour**
- **½ lb. dried milk (reconstituted with 1 gal. water)**
- **¼ c. sherry wine for cooking**
- **1 lb. 4 oz. spaghetti, broken**
- **1 gal. water, boiling**
- **2 tbsp. salt**
- **1 tbsp. salt**
- **¼ tsp. pepper**
- **½ c. grated cheese**
- **½ c. parsley, chopped**

1. Prepare the turkey; cut into large cubes.

2. Heat turkey stock.

3. Saute mushrooms, onions and garlic salt in turkey fat. Add flour.

4. Add mixture to hot turkey stock and cook until thickened, stirring constantly with a wire whip.

5. Add the reconstituted dried milk and sherry wine.

6. Cook the spaghetti in the boiling salted water until tender. Drain and rinse with cold water.

7. Combine spaghetti, cooked turkey, sauce, salt and pepper, Check for seasonings.

8. Place the mixture in casserole dishes, using six ounces per portion. Sprinkle the grated cheese on top.

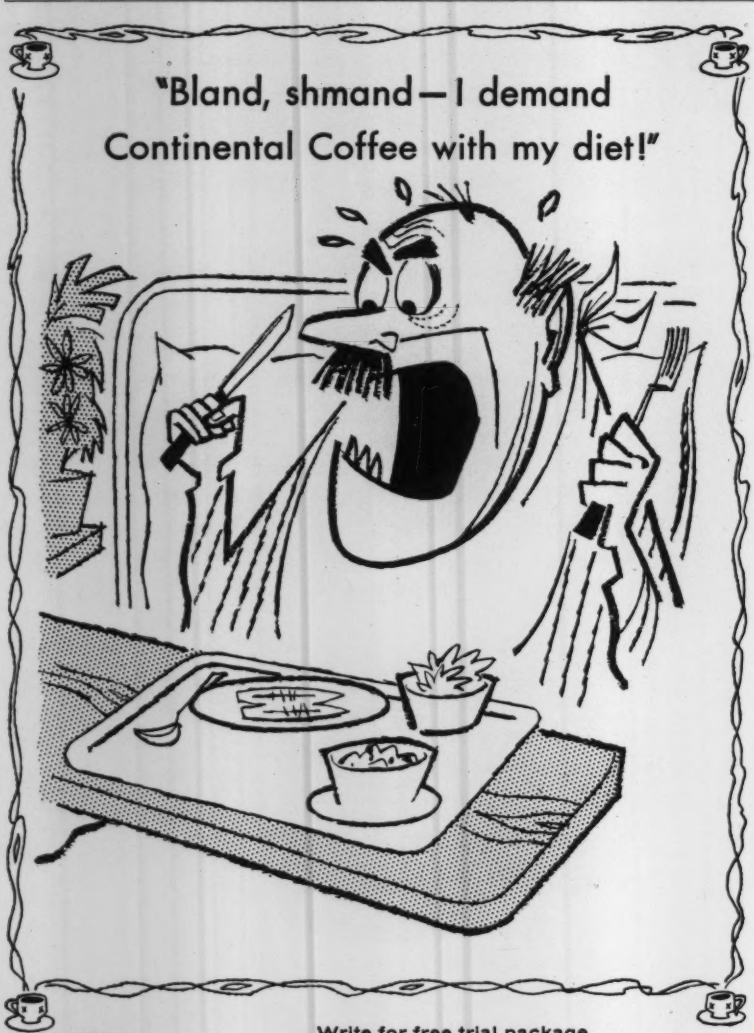
9. Bake at 400° F. until tetrazzini is bubbly and the cheese is melted.

10. Garnish with chopped parsley before serving.

BAKED EGGPLANT
(100 servings)

- **30 lbs. eggplant**
- **4 qts. flour**
- **½ c. salt**
- **1 tbsp. pepper**
- **1 tbsp. paprika**
- **1 pt. egg yolks**
- **3½ qts. milk**
- **5 qts. bread crumbs**
- **6 lbs. mushrooms (sliced)**
- **1½ c. shortening**
- **3 gal. medium white sauce**
- **2 lbs. pecans**

1. Peel eggplant and cut cross-



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wise in slices three-quarters inch thick.

2. Combine flour and seasonings.

3. Blend egg yolks and milk.

4. Turn slices of eggplant in seasoned flour, dip in egg mixture and then bread crumbs.

5. Fry in deep fat at 350° F.

6. Saute mushrooms in shortening and add to white sauce.

7. Arrange slices overlapping in a small pan (10 by 12 inches), not more than 10 portions per pan.

8. Cover with 1½ qts. mushroom sauce. Sprinkle with ¾ c. pecans.

9. Reheat in oven at 375° F. for 10-15 minutes.

10. Use 2 large or 3 small pieces of eggplant per serving.

PECAN PIE

(Four, 9-inch pies or 3 qts.)

⅔ c. melted butter
2 lbs. 3 oz. brown sugar
15 eggs
3 lbs. 12 oz. white syrup
¾ tsp. salt
1⅔ tbsp. vanilla
12 oz. pecan pieces

1. Cream melted butter and brown sugar.

2. Add unbeaten eggs and mix well.

3. Add syrup, salt and vanilla. Combine thoroughly.

4. Pour 3 cups filling into each pie shell.

5. Sprinkle 3 oz. pecan pieces on top of each pie.

6. Bake pies in 390° F. oven for 40-45 min. or until knife comes out clean when inserted in pie. ■

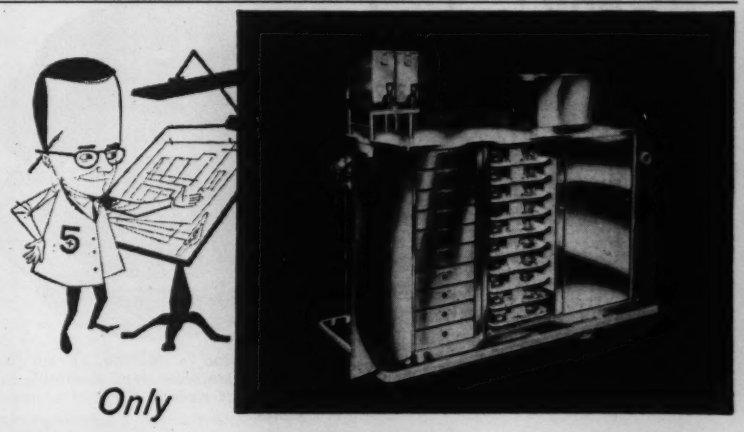
Dietary booklet for patients saves time and tempers

Assuming that patients will be more receptive to hospital food service, regulations and modifications if they are informed of the procedures, United Hospital in Port Chester, New York, has developed a booklet for patients on the "why" and "how" of hospital food service. Entitled "Food for Thought—Dietary Tid Bits for Your Consumption," this booklet explains the functions and staffing of the dietary department, the doctor's role in dietary prescription, the selective menu, the duties of the tray girls, the hours of meal service, and to whom to direct complaints.

Geraldine Gamache, the hospital's chief dietitian, reports that the booklet has been written in very simple language so it can be easily understood by all patients. The booklet saves the doctors, nurses and dietitians a great deal of time and cuts down on patient aggravation, for the patient knows exactly whom to contact for any changes or suggestions on meal service. ■

Fall Cycle Menu for the East

THE 21-DAY selective fall cycle menu and market orders for perishables are designed for hospitals in the East. These menus, which are to be used during September, October and November, feature foods popular in the eastern section of the United States.



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American Hospital Assn., Booth 1138, N.Y.C., August 24-27

The menus in this issue are the third in a four-part-series of fall cycle menus published in this Journal. Fall cycle menus for the Midwest and South-Southwest were included in the July 1 and 16 issues of HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. Fall menus for hospitals in the North-Northwest will be published in the August 16 issue.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. Moreover, a moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

In adapting items marked (S) for use on modified diets, it should be noted that certain items will need sodium or fat restriction during preparation, if they are to be served on sodium restrictive or fat restrictive diets. When fruits are included on the dessert menu, the dietitian will omit sugar or substitute the water-packed variety for the diabetics.

The summer cycle menus, for use during August, were published in the April and May 1959 issues of this Journal. The Midwest and South-Southwest cycle menus were included in the April 1 and 16 issues, respectively. The May 1 and 16 issues featured summer menus for the East and North-Northwest, respectively.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other preprepared items.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

The standard is available upon request from the Association, 840 North Lake Shore Drive, Chicago 11, Ill.

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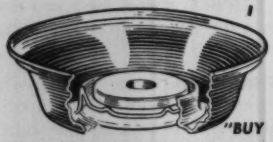

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1st WEEK EAST SELECTIVE FALL CYCLE MENU

(MENUS TO BE USED DURING SEPTEMBER, OCTOBER AND NOVEMBER)

—prepared by Elma Frazer Perry, formerly chief dietitian, Memorial Center for Cancer and Allied Diseases, New York*

	breakfast	noon	night
monday	Stewed Apricots **or** Apple Juice Rolled Oats Cereal **or** Corn Flakes Soft Cooked Egg— Sausage Links Cheese Danish	French Onion Soup—Parmesan Cheese Veal Parmesan **or** Broiled Salisbury Steak—Mushroom Gravy (FS) Parsley Buttered Potato (FS) Buttered Green Beans (FS) **or** Glazed Parsnips Romaine, Orange and Avocado Salad—Fruit Dressing **or** Under-the-sea Salad—Mayonnaise Banana Shortcake—Whipped Cream **or** Chocolate Pudding—Cream (FS)	Tomato Juice—Lemon Wedge Hot Turkey Sandwich—Gravy—Cranberry Sauce (FS) **or** Chili Con Carne on Rice Escalloped Potato Creamed Silver Onions **or** Baked Acorn Squash (FS) Grapefruit Salad—Blue Cheese Dressing **or** Vitamin Salad—French Dressing Blueberry Pie (F) **or** Orange Sherbet (S)
tuesday	Fresh Orange Slices (F) **or** Pear Nectar Whole Wheat Cereal **or** Ready-to-Eat Cereal French Toast— Hot Syrup Bran Muffin	Southern Bisque—Rye Croutons Sauerbraten—Gravy (F) **or** Chicken a la King on Holland Rusk (S) Mashed Potatoes (F) Buttered Asparagus (FS) **or** Cream Style Corn Carrot & Celery Sticks **or** Mixed Fruit Salad—Fruit Dressing Apple-Cheese Crisp—Whipped Cream (F) **or** Bing Cherries in Syrup (S)	Fresh Fruit Cup Roast Fresh Ham—Spiced Crabapple (F) **or** Meat Loaf—Vegetable Gravy (S) Candied Yams (FS) Cauliflower Au Gratin **or** Buttered Peas (FS) Frozen Fruit Salad **or** Coleslaw and Spinach—Sour Cream Dressing Baked Custard (FS) **or** Fruit Cocktail
wednesday	Stewed Prunes **or** Tomato Juice Farina **or** Bran Flake Cereal Corned Beef Hash with Poached Egg Doughnut	Scotch Broth—Toasted Croutons Roast Leg of Lamb—Mint Sauce (FS) **or** Italian Spaghetti—Parmesan Cheese Whipped Potato (FS) Creamed Spinach **or** Buttered Whole Beets (FS) Molded Oranges, Cream Cheese and Grapefruit Salad **or** Garden Salad—Roquefort Dressing Gingerbread with Lemon Sauce (F) **or** Applesauce (S)	Fruit Punch Corned Beef with Horseradish Sauce (F) **or** Baked Macaroni and Cheese in Casserole (S) Boiled Whole Potato (F) Buttered Cabbage Wedge (F) **or** Buttered Whole Carrots (FS) Stuffed Apricot Salad **or** Sliced Tomatoes on Lettuce—Mayonnaise Maple Nut Chiffon Cake (F) **or** Sliced Canned Peaches in Syrup (S)
thursday	Half Grapefruit Garnished with Maraschino Cherry (F) **or** Apricot Nectar Hominy Grits **or** Shredded Wheat Cereal Pancakes—Maple Syrup Crumb Coffee Cake	Split Pea Soup Barbecued Spareribs (F) **or** Spanish Omelet (S) Au Gratin Potato (FS) Buttered Wax Beans (FS) **or** Sauerkraut (F) Jellied Vegetable Salad **or** Chef's Salad—French Dressing Pecan Pie (F) **or** Bartlett Pear Half in Syrup (S)	Apple Juice Barbecued Breast of Veal **or** Hamburger on a Bun—Relish (FS) French Fried Potatoes (F) Stewed Tomatoes with Okra (F) **or** Buttered Carrots (S) Molded Shredded Carrot and Pineapple Salad—Mayonnaise **or** Lettuce Wedge—Pimento Strip—Roquefort Dressing Boston Cream Pie (F) **or** Royal Anne Cherries in Syrup (S)
friday	Kadota Figs **or** Grape Juice Wheat Farina **or** Puffed Rice Cereal Scrambled Egg— Bacon Strips Danish Pastry	Manhattan Clam Chowder Broiled Swordfish Steak (FS)—Tartar Sauce (F) **or** Chicken Fricassee on Rice Parsley Buttered Potato (FS) Baked Eggplant **or** Mashed Butternut Squash (FS) Tossed Salad—1000 Island Dressing **or** Blushing Pear Salad Tapioca Pudding (FS) with Mandarin Orange and Coconut Garnish (F) **or** Whole Peeled Apricots in Syrup	Cranberry Juice Cocktail Roast Sirloin of Beef Au Jus **or** Crabmeat Cutlet (FS)—Tartar Sauce Demonico Potato (FS) Creamed Peas (FS) **or** Whole Kernel Corn with Pimentos Raisin and Carrot Salad—Mayonnaise **or** Red Cabbage Slaw Lemon Chiffon Pie (F) **or** Sliced Canned Peaches in Syrup (S)
saturday	Sliced Banana **or** Orange Juice Malt Cereal **or** Ready-to-Eat Rice Cereal Waffles—Hot Syrup Cheese Muffin	Turkey-Noodle Soup—Oyster Crackers Baked Virginia Ham—Raisin Sauce (F) **or** Broiled Liver—Bacon Strip (S) Baked Sweet Potatoes (FS) Buttered Chopped Swiss Chard (FS) **or** Braised Celery and Mushrooms Watercress and Endive Salad—Italian Dressing **or** Molded Gingerale and Applesauce Salad—Mayonnaise Floating Island (FS) **or** Purple Plums in Syrup	Peach Nectar Broiled Loin Lamb Chop—Hot Minted Peach Half (S) **or** La Sagna—Parmesan Cheese (F) Creamed Potatoes (FS) Buttered Broccoli (F) **or** Buttered Zucchini Squash (S) Coconut, Celery and Apple Salad **or** Shredded Escarole—Chiffonade Dressing Cupcakes with Butter Frosting (F) **or** Mandarin Oranges (S)
sunday	Mandarin Orange Sections **or** Pineapple Juice Oatmeal **or** Corn Flakes Soft Cooked Egg— Canadian Bacon French Crueller	Cream of Carrot Soup Roast Cornish Hen—Gravy—Yellow Rice Stuffing (FS)—Grilled Tomato (F) **or** Grilled Cheese Sandwich—Pickle Mashed Potatoes (FS) Buttered Mixed Vegetables (F) **or** Asparagus and Beet Salad (S) Peach Half—Sour Cream Dressing **or** Cabbage Slaw with Almonds and Pineapple Green Gage Plums **or** Creme de Menthe Parfait (FS)	Sherry Consomme Deluxe Sliced Filet Mignon—Mushroom Gravy (S) **or** Salad Bowl: Deviled Egg— Tomato Wedge—Potato Salad—Swiss Cheese—Ripe Olives (F) Baked Idaho Potatoes (S) **or** French Bread (F) French-Style Green Beans (FS) **or** Buttered Peas Tossed Salad—French Dressing **or** Diced Beets—Celery and Corn Garnish Royal Anne Cherries in Syrup **or** Angel Food Cake—Lemon Sauce (FS)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

*On June 1 Mrs. Perry retired from her position at the hospital to become a full-time homemaker.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings		
BEEF		
Brisket, Corned	U. S. Good	20 lbs. 60
Ground Beef	U. S. Good, 5 lb. pkg.	70 lbs.
Liver	Steer, sliced	5 lbs. 20
Roast, Sirloin (B.R.T.)	U. S. Choice	7 lbs.
Round (Bottom)	U. S. Standard	35 lbs.
Tenderloin Tip	U. S. Good	7 lbs.
LAMB		
Chops, Loin	U. S. Choice, 6 oz. each	23 lbs. 60
Leg (B.R.T.)	U. S. Choice, yearling	27 lbs.
PORK		
Bacon, Canadian		5 lbs.
Bacon (Sliced)	24-26-1 lb.	6 lbs.
Ham, Fresh (B.R.T.)	Grade A	20 lbs. 60
Ham (Pullman)	Ready-to-eat	35 lbs.
Sausage Links	12-1 lb.	10 lbs.
Spareribs	Grade A, 3-1 lb.	50 lbs.
VEAL		
Breast	U. S. Good	7 lbs.
Leg (B.R.T.)	U. S. Good	13 lbs.
FISH		
Swordfish	Steaks, 5 oz. each	25 lbs. 80
POULTRY		
Fowl (Eviscerated)	Grade A, 5 lb. av.	50 lbs.
Hens, Rock Cornish Game	Grade A, 1 lb. av.	80 lbs.
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	45 lbs.
FRESH FRUITS		
Apples	Jonathan, 113s	1 box
Avocado	Ripe	5 only
Bananas	Ripe	40 lbs.
Grapefruit	Seedless, 70s	1 box
Lemons		1 doz.
Oranges	176s	1 box
FRESH VEGETABLES		
Cabbage	Bag	50 lbs.
Cabbage, Red		15 lbs.
Carrots	Topped, bag	50 lbs.
Celery	Pascal, 30s	1 doz. stalks
Celery	White	6 stalks
Cucumbers		1 doz.
Eggplant		3 only
Endive	Curly	5 heads
Escarole		6 heads
Lettuce	Head, 48s	1 crate
Onions, Dry	Yellow, bag	50 lbs.
Onions, Green	Bunch	1 doz.
Onions, White	Boilers	3 lbs.
Parsley	Bunch	1 doz.
Parsnips		5 lbs.
Potatoes, Sweet	Hamper	50 lbs.
Potatoes, White	Bag No. 1	400 lbs.
Radishes	Bunch	1 doz.
Romaine		6 heads
Spinach	Processed, 10-12 oz. bag	6 bags
Squash, Acorn		30 lbs.
Squash, Butternut		25 lbs.
Squash, Zucchini		5 lbs.
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)
Watercress	Bunch	6 bunches
FROZEN FRUITS		
Apples	Sliced, 8 lb. can, 5-1 sugar	16 lbs.
Blueberries	Dry, 8 lb. can	16 lbs.
Grapefruit Sections	Fresh, chilled, 1 gal.	2 gal.
Orange Juice	Con., 32 oz. can	6 cans
FROZEN VEGETABLES		
Asparagus	Spears, 2½ lb. pkg.	15 lbs. 90
Beans, Green	Cuts, 2½ lb. pkg.	15 lbs. 90
Beans, Green	Julienne, 2½ lb. pkg.	10 lbs. 60
Beans, Wax	Cuts, 2½ lb. pkg.	15 lbs. 90
Broccoli	Stems and buds 2½ lb. pkg.	10 lbs. 60
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs. 15
Chard, Swiss	2½ lb. pkg.	2½ lbs. 15
Peas	2½ lb. pkg.	22½ lbs. 135
Spinach	Chopped, 2½ lb. pkg.	2½ lbs. 15
Vegetables, Mixed	2½ lb. pkg.	15 lbs. 90

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2nd WEEK EAST SELECTIVE FALL CYCLE MENU

(MENUS TO BE USED DURING SEPTEMBER, OCTOBER AND NOVEMBER)

—prepared by Elma Frazer Perry, formerly chief dietitian, Memorial Center for Cancer and Allied Diseases, New York*

	breakfast	noon	night
monday	Stewed Rhubarb or Tomato Juice Oats Cereal or Corn Flakes Soft Cooked Egg— Crisp Bacon Strips Crumb Coffee Cake	Mulligatawny Soup Braised Turkey Wings (FS) or Ravioli—Parmesan Cheese Boiled Potato (FS) Buttered Brussels Sprouts (F) or Minted Carrot Pennies (S) Banana Rolled in Corn Flakes—Mayonnaise or Chives and Cottage Cheese Salad Chocolate Eclairs (F) or Applesauce (S)	Pineapple Juice Breaded Pork Steak—Apple Ring (F) or Beef Turnovers—Mushroom Gravy (S) Mashed Potato (F) Buttered Asparagus (FS) or Beets in Orange Sauce Stuffed Prunes with Peanut Butter and Cream Cheese or Tomato Aspic with Celery Honey Custard (FS) or Melon Balls—Mint Garnish
tuesday	Fresh Red Apple (F) or Apricot Nectar Wheat Farina or Ready-to-Eat Rice Cereal French Toast— Hot Syrup Raisin Muffin	Oxtail Soup Tongue a la Maryland or Lamb Patty Wrapped in Bacon—Mint Jelly (FS) Baked Idaho Potato (FS) French Fried Cauliflower (F) or Buttered Chopped Spinach (S) Curry Coleslaw or Stuffed Celery Cheese Cake (F) or Sliced Peaches in Syrup (S)	Broiled Half Grapefruit Veal Cutlet—Tomato Sauce (FS) or Fluffy Cheese and Rice Omelet Country Fried Potato (F) or Baked Potatoes Buttered Wax Beans (FS) or Buttered Lentils Mountaineer Salad or Molded Cucumber Salad Cherry Pie (F) or Bartlett Pear Half in Syrup (S)
wednesday	Orange Halves or Grape Juice Oatmeal or Puffed Rice Cereal Coddled Egg— Pan-Fried Potatoes Cheese Danish	Cheese—Vegetable Soup Broiled Breast of Chicken—Lemon Tarragon Butter (FS) or Braised Sweetbreads—Mushroom Gravy Baked Potato (FS) Savory Onions or Buttered Peas (FS) Mixed Green Salad—Italian Dressing or Marinated Vegetable Salad—Mayonnaise Blueberry Shortcake—Whipped Cream (F) or Whole Peeled Apricots in Syrup (S)	Apple Cider Broiled Club Steak (FS) or Veal and Peppers with Tomato Sauce Parsley Buttered Potato (FS) French Fried Eggplant (F) or Buttered Hubbard Squash (S) Molded Cider Salad or Wilted Lettuce Salad with Onion—Hot Bacon Dressing Lemon Sherbet (FS) or Baked Apple
thursday	California Sliced Frozen Peaches or Pineapple Juice Farina or Bran Cereal Waffles—Hot Syrup Spice Muffin	Beef and Noodle Soup Hot Roast Fresh Ham Sandwich—Applesauce (F) or Cheese Fondue (S) Mashed Sweet Potato (FS) Buttered Asparagus (S) or Succotash (F) Cranberry and Apple Relish Salad or Asparagus and Sliced Egg Salad Strawberry Chiffon Pie (F) or Royal Anne Cherries in Syrup (S)	Fruit Cocktail Roast Turkey—Gravy (FS)—St ffing—Cranberry Sauce (F) or Shepherd's Pie Mashed Potato (FS) Buttered Broccoli or Julienne Fresh Carrots (FS) Perfection Salad or Celery Sticks, Pickle Chips and Black Olives Jelly Roll (FS) or Stewed Rhubarb
friday	Stewed Fruit Compote or Orange Juice Rolled Oats Cereal or Rice Cereal Scrambled Egg— Canadian Bacon Sugary Apple Muffin	Oyster Stew—Saltines Baked Loin Pork Chop—Applesauce or Seafood Newburg on Toast Points (FS) Lyonnaise Potato Frenched Green Beans and Sliced Mushrooms (FS) or Southern Style Corn Pudding Ambrosia Salad or Orange, Cabbage and Green Pepper Slaw Pumpkin Pie (F) or Applesauce (S)	Apricot Nectar Broiled Nova Scotia Salmon (FS)—Tartar Sauce (F) or Meat Loaf—Mushroom Gravy Steamed Potato in Jacket (FS) Buttered Zucchini Squash (S) or Broiled Tomato Half (F) Pear and Bing Cherry Salad—Honey Cream Dressing or Chef's Salad—French Dressing Gelatin Whip (FS) or Fresh Fruit Cup—Mint
saturday	Pink Applesauce Garnish with Banana Slice or Prune Juice Rice Farina or Puffed Wheat Cereal Pancakes—Hot Syrup Doughnut	Chicken-Gumbo Soup Swiss Steak—Gravy (F) or Spanish Rice—Bacon (S) Whipped Potato (F) French Fried Parsnip Chips or Buttered Spinach (FS) Pickled Beet Salad or Tossed Green Salad—Italian Dressing Old Fashioned Bread Pudding—Vanilla Sauce (FS) or Kadota Figs	Tangerine Juice Veal Scallopini (F) or Hamburger—Roll—Relish (S) French Fried Potato (F) Buttered Carrots (S) or Buttered Turnips (F) Orange, Pineapple and Marshmallow Salad or Asparagus and Sliced Egg Salad Maple Eclairs (F) or Royal Anne Cherries in Syrup (S)
sunday	Fresh Grapefruit Sections or Peach Nectar Whole Wheat Cereal or Corn Flakes Scrambled Egg— Bacon Curls Cranberry Muffin	Cream of Asparagus Soup Roast Sirloin of Beef Au Jus (FS) or Salad Plate: Cottage Cheese Finger Sandwiches on Date-Nut Bread, Banana Half, Apricot, Pineapple Ring Whipped Potato (FS) or Blueberry Muffin Creamed Peas and Mushrooms (FS) or Buttered Cauliflower Lettuce and Tomato Salad—French Dressing or Pineapple and Grated Cheese Salad Bartlett Pear Half in Syrup (S) or Tomato Soup Cake—Butter Frosting (F)	Vegetable Juice Cocktail Baked Sugar Cured Ham with Orange Sauce (F) or Cheese Strata (S) Candied Sweet Potato (FS) Buttered Wax Beans (S) or Buttered Kale (F) Jellied Apricot Salad or Red Cabbage Slaw Butterscotch Pudding—Whipped Cream (FS) or Sliced Bananas in Cream

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

*On June 1 Mrs. Perry retired from her position at the hospital to become a full-time homemaker.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Ground Beef	U. S. Good, 5 lb. pkg.	25 lbs.	
Roast, Sirloin (B.R.T.)	U. S. Choice	27 lbs.	
Steaks, Club	U. S. Choice, 5 oz. ea.	18 lbs.	60
Steak, Swiss	U. S. Good, 4 oz. each	25 lbs.	100
Tongue	No. 1	15 lbs.	
LAMB			
Ground, Shoulder	U. S. Good	20 lbs.	80
PORK			
Bacon, Canadian		5 lbs.	
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Chops, Loin	Grade A, 4 oz. each	10 lbs.	40
Ham, Fresh (B.R.T.)	Grade A	35 lbs.	
Ham (Pullman)	Ready-to-eat	20 lbs.	60
Steaks (Boneless)	Grade A, 4 oz. each	15 lbs.	60
VEAL			
Cutlets	U. S. Good, 4 oz. each	15 lbs.	60
Shoulder (Boneless)	U. S. Good	27 lbs.	
Stew	U. S. Good	5 lbs.	
Sweetbreads	Fresh	15 lbs.	
FISH			
Salmon	Red, steaks, 5 oz. ea.	18 lbs.	
POULTRY			
Breast, Chicken		25 lbs.	

Item, Specifications, Amounts & No. of Servings			
Turkeys (Eviscerated) Grade A, 20-24 lb. av.		45 lbs.	
Turkey Wings		30 lbs.	80
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Bananas	Ripe	40 lbs.	
Cranberries	1 lb. bag	3 lbs.	
Grapefruit	Seedless, 70s	1 box	
Lemons		1 doz.	
Oranges	176s	1 box	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Cabbage, Red		15 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 doz. stalks	
Celery	White	6 stalks	
Cucumbers		1 doz.	
Eggplant		5 only	
Endive	Curly	6 heads	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Onions, White	Boilers	3 lbs.	
Parsley	Bunch	1 doz.	
Parsnips		5 lbs.	
Peppers, Green		1 doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Romaine		6 heads	

Item, Specifications, Amounts & No. of Servings			
Squash, Hubbard		7 lbs.	
Squash, Zucchini		5 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
Turnips, White	Topped	20 lbs.	
Watercress	Bunch	6 bunches	
FROZEN FRUITS			
Blueberries	8 lb. can, 5-1 sugar	24 lbs.	
Cherries	5-1 sugar, pitted, 8 lb. can	16 lbs.	
Grapefruit Sections	Fresh, chilled, 1 gal.	2 gal.	
Melon Balls	8 lb. can	8 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Peaches	Sliced, 8 lb. can, 5-1 sugar	8 lbs.	
Rhubarb	8 lb. can, 5-1 sugar	16 lbs.	
Strawberries	Sliced, 8 lb. can, 5-1 sugar	24 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	12½ lbs.	75
Beans, Green	Julienne, 2½ lb. pkg.	15 lbs.	90
Beans, Wax	Cuts, 2½ lb. pkg.	12½ lbs.	75
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	15 lbs.	90
Cauliflower	Buds, 2½ lb. pkg.	17½ lbs.	105
Kale	2½ lb. pkg.	10 lbs.	60
Peas	2½ lb. pkg.	30 lbs.	180
Spinach	Chopped, 2½ lb. pkg.	17½ lbs.	105
Succotash	2½ lb. pkg.	15 lbs.	90

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Chefs prepare food on modern Gas equipment in the kitchen of Roanoke Memorial Hospital

Enough fried chicken for 300 patients in 12 minutes . . . thanks to *GAS*

Modern stainless steel Gas equipment with automatic controls is the key to fast preparation of special and regular diet foods at Roanoke Memorial Hospital, Roanoke, Virginia.

Stainless steel pressure cookers and steam kettles can cook enough fried chicken in 12 minutes to serve 300 patients, after which chicken is browned in a Gas-fired deep fat fryer. Automatically controlled Vulcan Gas equipment—ranges, baking and warming ovens—speed nutritious, tasty food to patients and staff with no interruption in service for changeover to special diets.

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3rd WEEK EAST SELECTIVE FALL CYCLE MENU

(MENUS TO BE USED DURING SEPTEMBER, OCTOBER AND NOVEMBER)

—prepared by Elma Frazer Perry, formerly chief dietitian, Memorial Center for Cancer and Allied Diseases, New York*

	breakfast	noon	night
monday	Pear Halves or Grapefruit Juice Farina or Ready-to-Eat Wheat Flake Cereal Scrambled Egg—Pan Fried Potatoes Blueberry Muffin	Tomato Bouillon—Saltines Broiled Flank Steak (FS) or Turkey Tetrazzini Mashed Potato (FS) Buttered Tiny Whole Beets (FS) or Buttered Lentils Celery Curls, Radish Roses and Olives or Mandarin Orange and Date Salad—Mayonnaise Apple Cobbler—Whipped Cream (FS) or Sliced Peaches in Syrup	Apple-Cranberry Cocktail Roast Leg of Lamb—Mint Sauce (FS) or Chinese Chow Mein—Fried Noodles Buttered Rice or Baked Potato (FS) Escalloped Tomato or Buttered Wax Beans (FS) Orange-Cream Cheese Sandwich Salad or Fresh Garden Salad—Blue Cheese Dressing Devil's Food Cake (F) or Whole Peeled Apricots in Syrup (S)
tuesday	Frozen Melon Balls or Prune Juice Oats Cereal or Puffed Rice Cereal Pancakes—Maple Syrup Cheese Danish	Cream of Spinach Soup Braised Short Ribs of Beef (F) or Welsh Rarebit on Toast Points (S) Oven-browned Potato (F) Buttered Asparagus Tips (FS) or Mashed Rutabagas Avocado and Grapefruit Salad or Vitamin Salad—Tangy Dressing Butterscotch Sundae (FS) or Fruit Compote	Grape Juice Yankee Pot Roast—Gravy (FS) or Brown Fricassee of Veal on Rice Buttered Potato (FS) Buttered Green Beans (FS) or Buttered Mixed Vegetables Waldorf Salad or Curry Cole Slaw Chocolate Cupcake (F) or Royal Anne Cherries in Syrup (S)
wednesday	Baked Apple or Blended Juice Whole Wheat Cereal or Ready-to-Eat Rice Cereal Coddled Egg—Sausage Links Corn Muffin	Hot Ruby Consomme—Oyster Crackers Grilled Ham Steak—Pineapple Fan (F) or Broiled Chicken Livers with Mushrooms (S) Baked Sweet Potato (FS) Buttered Broccoli or Baked Acorn Squash (FS) Molded Roquefort Salad or Tomato Wedges on Lettuce—French Dressing Lemon Creamy Rice Pudding (FS) or Fresh Fruit Cup—Mint	Mixed Fruit Punch Chopped Sirloin Steak (FS) or Broiled Loin Lamb Chop—Mint Jelly Steamed Potato (FS) Buttered Brussels Sprouts or Buttered Carrot Strips (FS) Pineapple Ring and Apricot Half with Cottage Cheese or Tossed Salad—Chiffonade Dressing Rum Chiffon Pie (F) or Bartlett Pear Half in Syrup (S)
thursday	Fresh Orange Sections (F) or Peach Nectar Rolled Oats Cereal or Ready-to-Eat Cereal French Toast—Hot Syrup Doughnut Twist	Cream of Pea Soup Hot Turkey Sandwich (FS)—Gravy—Cranberry Sauce (F) or Stuffed Green Peppers—Tomato Sauce Mashed Potato Buttered Spinach (FS) or Buttered Whole Kernel Corn Banana-Nut Salad with Sour Cream Dressing or Watercress and Endive Salad with Italian Dressing Mince Pie (F) or Applesauce (S)	Honey Dew Melon Wedge Roast Loin of Fresh Pork—Hot Applesauce (FS) or Spaghetti with Meat Balls—Parmesan Cheese Escalloped Potato (FS) Sweet and Sour Red Cabbage or Buttered Peas (FS) Cucumbers, Pineapple and Celery in Lime Gelatin—Mayonnaise or Lettuce Hearts—Roquefort Dressing Sponge Cake (FS) or Stewed Rhubarb
friday	Royal Anne Cherries in Syrup or Orange Juice Rice Farina or Ready-to-Eat Malt Flake Cereal Scrambled Egg—Bacon Curls Date and Nut Muffin	New England Clam Chowder Poached Fillet of Sole—Wine Sauce (FS) or Cabbage Roll—Tomato Sauce Hash Browned Potato (FS) Lima Beans in Cream or Buttered Wax Beans (FS) Chef's Salad—Russian Dressing or Frozen Fruit Salad Chocolate Sundae (FS) or Fresh Seedless Grapes	Fresh Fruit Cup (F) Beef Stroganoff or Tuna-Cheese Burger (FS) Paprika Potato Creamed Silver Onions or Baked Butternut Squash (FS) Molded Tomato, Onion and Celery Aspic or Mixed Fruit Salad—Peanut Butter Dressing Rice Custard (FS) or Green Gage Plums in Syrup
saturday	Fresh Red Grapes (F) or Apple Juice Hominy Grits or Ready-to-Eat Cereal Corn Beef Hash with Poached Egg Danish Pastry	Italian Minestrone Soup Lamb Stew (FS) or Beef Pinwheels Spanish Mashed Potato Cauliflower Polonaise or Buttered Beets (FS) Molded Bing Cherry, Olive and Nut Salad or Cucumber Vinegrette Hermits (F) or Peach Halves in Syrup (S)	Tomato Juice—Lemon Wedge Broiled Canadian Bacon—Pineapple Sauce or Chicken Pot Pie (FS) Buttered Rice Buttered Kale or Buttered Asparagus (FS) Stuffed Peach Salad or Carrot and Celery Sticks Lemon Meringue Pie (F) or Bartlett Pears in Syrup (S)
sunday	Pink Grapefruit Half (F) or Pear Nectar Malt Cereal or Puffed Rice Cereal Waffles—Hot Syrup Jelly Doughnut	Chicken Leek Soup—Crackers Roast Long Island Duckling—Orange Slice (F) or Broiled Loin Lamb Chop (S) Whipped Potato (FS) Buttered Zucchini Squash (FS) or Escalloped Eggplant Princess Salad—Honey Cream Dressing or Shredded Chinese Cabbage—1000 Island Dressing Apple Pie a la Mode (F) or Royal Anne Cherries in Syrup (S)	Chilled Orange Juice Boiled Beef (FS)—Horseradish Sauce (F) or Salad Plate: Ham and Cheese Strips, Sliced Hard-Cooked Egg, Sliced Tomato, Potato Chips, Pickles Lyonnaise Potato (FS) Buttered Cabbage Wedge (F) or Buttered Green Beans (FS) Sliced Orange Salad—Celery Seed Dressing or Asparagus and Pimento Salad Lemon Sherbet (FS) or Melon Balls with Mint

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

*On June 1 Mrs. Perry retired from her position at the hospital to become a full-time homemaker.

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Fresh	U. S. Choice	20 lbs.	60
Ground Beef	U. S. Good, 5 lb. pkg.	35 lbs.	
Round (Bottom)	U. S. Standard	27 lbs.	
Short Ribs	U. S. Choice	50 lbs.	
Sirloin, Chopped		20 lbs.	60
Steaks, Flank	U. S. Choice	27 lbs.	
Stew	U. S. Good	5 lbs.	20
LAMB			
Chops, Loin	U. S. Choice, 6 oz. ea.	25 lbs.	
Leg (B.R.T.)	U. S. Choice, yearling	20 lbs.	60
Stew	U. S. Good	20 lbs.	80
PORK			
Bacon, Canadian		5 lbs.	
Bacon (Sliced)	24-26-1 lb.	6 lbs.	
Ham (Pullman)	Ready-to-eat	40 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	20 lbs.	60
Sausage Links	12-1 lb.	6 lbs.	
VEAL			
Shoulder (Boneless)	U. S. Good	7 lbs.	20
FISH			
Sole	Frozen, fillets	20 lbs.	80
POULTRY			
Duck		80 lbs.	
Fowl (Eviscerated)	Grade A, 5 lb. av.	60 lbs.	

Item, Specifications, Amounts & No. of Servings			
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	90 lbs.	
Livers, Chicken	1 lb. pkg.	5 lbs.	20
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Avocado	Ripe	5 only	
Bananas	Ripe	30 lbs.	
Grapefruit, Pinkmeat	Seedless, 70s	1 box	
Grapes	Emperor	10 lbs.	
Grapes	Seedless, 28 lb. box	1 box	
Lemons		1 doz.	
Oranges	176s	1 box	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Cabbage, Chinese		10 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 doz. stalks	
Celery	White	6 stalks	
Cucumbers		1½ doz.	
Eggplant		2 only	
Endive	Curly	6 heads	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Onions, White	Boilers	3 lbs.	
Parsley	Bunch	1 doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Rutabagas		5 lbs.	
Squash, Acorn		45 lbs.	

Item, Specifications, Amounts & No. of Servings			
Squash, Butternut		20 lbs.	
Squash, Zucchini		25 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
Watercress	Bunch	6 bunches	
FROZEN FRUITS			
Apples	Sliced, 8 lb. can, 5-1 sugar	40 lbs.	
Fruit, Mixed	8 lb. can, 5-1 sugar	16 lbs.	
Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
Melon Balls	8 lb. can	16 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Peaches	Sliced, 8 lb. can, 5-1 sugar	8 lbs.	
Rhubarb	8 lb. can, 5-1 sugar	8 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	25 lbs.	150
Beans, Green	Cuts, 2½ lb. pkg.	10 lbs.	60
Beans, Green	Julienne, 2½ lb. pkg.	10 lbs.	60
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs.	15
Beans, Wax	Cuts, 2½ lb. pkg.	25 lbs.	150
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Greens, Mustard	2½ lb. pkg.		
Kale	2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	10 lbs.	60
Spinach	Chopped, 2½ lb. pkg.	15 lbs.	90
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

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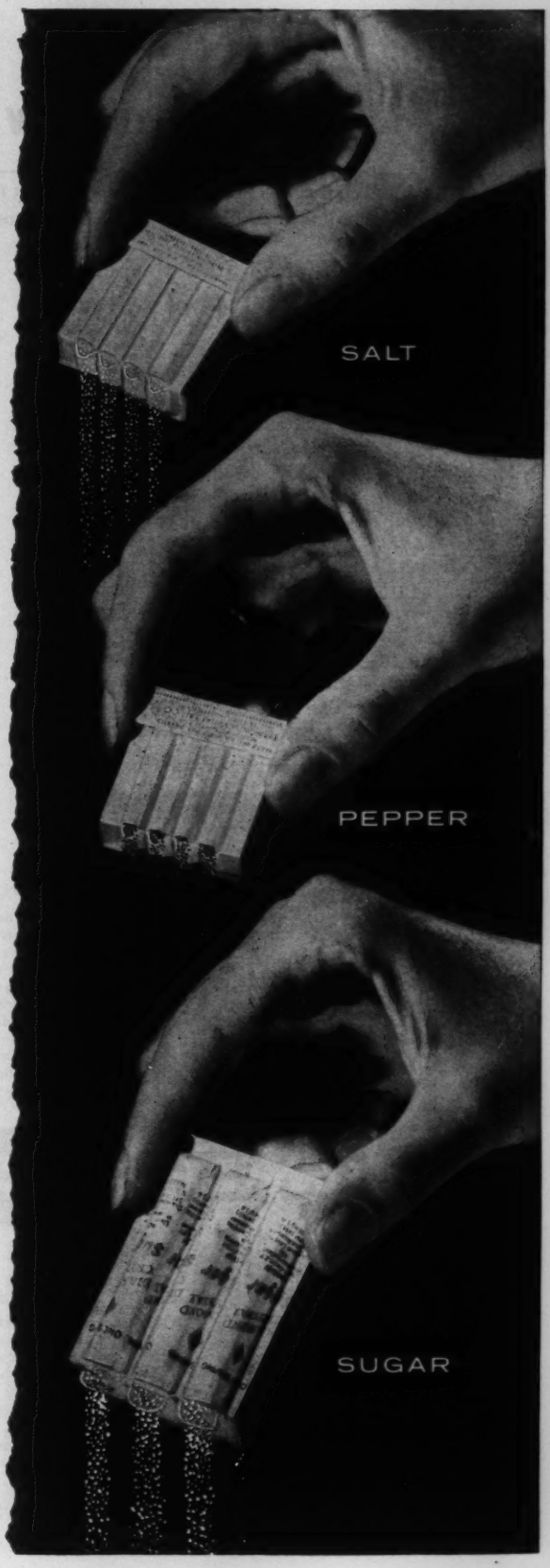

THE LAW IN BRIEF

Legal matters of interest to the hospital field prepared by the law department of the American Hospital Association

Medical Staff Suspensions

The validity of a medical staff suspension may turn on a fine point of law or procedure. Two recent cases are worth examining in this respect.

Whether a hospital constituted a voluntary nonprofit institution or a governmental function was the key to a New Mexico conflict. *Akopiantz v. Board of County Commissioners of Otero County,* 333 P 2d 611 (N.M., 1958). The plaintiff physician conceded that if the hospital was not governmental, he could not force his way onto the medical staff. His contention, however, was that whatever the trappings, this was a county hospital in which a licensed local physician has a right to practice.

Stated in very general terms, the law in most jurisdictions allows a licensed physician to use the facilities of a public hospital under reasonable regulations, but gives him no right of entry to voluntary or proprietary institutions. The New Mexico Supreme Court concurred in this view of the law in this case. Its attention was directed towards determining whether the hospital was public or private in order to ascertain the doctor's rights.

The doctor-plaintiff had had words with the hospital management. The latter felt the physician had made excessive demands of hospital personnel. Although not required by the hospital's bylaws, a hearing was granted by the governing board. As a consequence, the doctor's staff privileges were suspended and he sought redress in the courts.

STATUTE: HOSPITAL MAY BE LEASED

The applicable New Mexico statutes allow a county to purchase land, equipment and other materials necessary for the operation of a hospital. The laws also authorize a county to arrange for the operation of such a hospital by persons, firms or corporations upon conditions determined by the county commissioners. A lease of the hospital property also is authorized by statute.

The county provided the land in this instance. A

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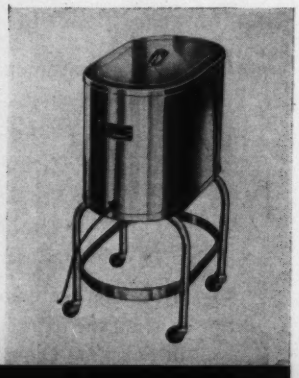

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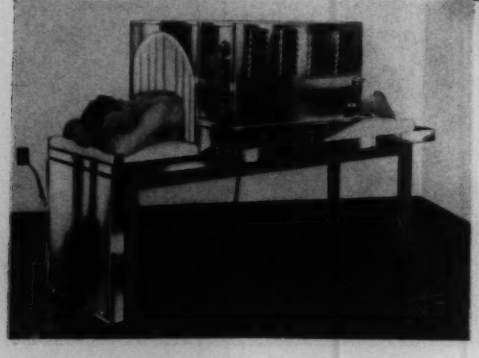
A DISTINGUISHED NAME IN HYDRO- AND PHYSICAL THERAPY EQUIPMENT



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county bond issue brought $50,000 and $67,000 was furnished by a Hill-Burton grant. The hospital was built but not operated by the county. A lease was negotiated with a nonprofit hospital corporation organized to manage the hospital. The corporation added $108,000 toward the funds necessary to complete the hospital. The lease ran for five years at a one dollar rental and was renewable under similar terms. Operation of the hospital was the responsibility of the board of the hospital corporation; the county commissioners did not participate in hospital management functions.

The court concluded that the county commissioners had properly availed themselves of a statutory privilege and had chosen to lease the hospital to the hospital association. The association was invested with exclusive rights of control and management of the institution. Therefore, the court held, the hospital was operated by a private (i.e. not public) corporation and was not a public institution even though owned by the county. The doctor's suspension was thus confirmed since the court would not review the administrative actions of a private hospital.

SUSPENDING UNNAMED PHYSICIAN

A more subtle, and less successful approach to medical staff censure involved a "nameless" physician. Upon recommendation of the hospital's medical board, the board of trustees voted to suspend staff privileges of an unnamed doctor for 30 days. When the chairman of the medical board attempted to fix the suspension period, the physician went to court to block the suspension.

The court enjoined the proposed suspension, condemning the action of the board to suspend an unnamed doctor on a hypothetical case reported out by the medical staff. The board of trustees did not know the identity of the doctor involved. The court described a medical staff appointment as a personal one. Members are granted staff privileges individually and by name. "Any action taken by the trustees against a staff appointee should be in relation to the particular appointment and directed against the particular individual personally."

The court noted that the governing board of the hospital—a voluntary nonprofit institution—could have discharged or suspended a staff appointee for violation of any reasonable regulation of the hospital, without providing opportunity for a hearing. The bylaws required no hearing prior to suspension, but they did not dispense with the need to designate the person to be censured. *Tschorn v. Northern Westchester Hospital Association, Inc.*, Sup. Ct. Westchester Co., N.Y., decided Dec. 3, 1958.

DEFINITION OF "HOSPITAL"

Research workers in the health field have had difficulty in formulating an acceptable definition of the term "hospital." The courts face this task also, but cannot procrastinate where such a definition is necessary to resolve a case. This situation arose in *Reserve Life Ins. Co. v Marr*, 254 F. 2d 289 (C.A. 9th, 1958).

The plaintiff insurance company wrote policies covering hospital expenses of the deceased. At the

(Continued on page 119)

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Take a Close Look at Hospital Injectables

Reading time: 2½ minutes **Benefits: 12**

There is little doubt that disposable equipment has assumed great importance in the modern hospital. Certainly, no hospital administrator would dispute the fact that disposable items such as knife blades, blood lancets, urine collection bags, catheters, and enemas all help increase efficiency and, often, cut costs.

On the other hand, much can be said for equipment of a more permanent nature. Personnel have usually had experience with it. There's no need for constant re-ordering; the cupboard is rarely bare.

You can have both

The advantages of disposable and permanent equipment do not necessarily have to be separate and distinct. In the TUBEX® closed-system of injectables, for example, the best features and advantages of both are combined. The system comprises a durable, finely made syringe and a disposable cartridge (glass) and needle unit containing a pre-measured dose of medication.

Injection with TUBEX *simply requires that the proper pre-filled cartridge-needle unit be selected, inserted in the syringe, and aspirated. After the injection has been given, the cartridge-needle unit is discarded; the syringe is ready to use again . . . and again . . . and again . . .*

The benefits that the TUBEX system brings to hospital personnel, and the contributions that it makes to hospital efficiency and the welfare of patients, are impressive. Consider, if you will, the following examples.

1. Accurately measured dose assured
2. Danger of giving wrong drug reduced

Each sterile cartridge-needle unit contains an accurate, clearly labeled dose. Therefore, the nurse no longer must measure out doses as before—perhaps from an often-used, possibly contaminated multiple-dose vial. She runs little risk of administering an inaccurate dose or, worse yet, the wrong drug entirely. Obviously, the less chance for error the fewer the number of malpractice suits.

3. Efficiency of Central Supply increased
4. Breakage losses reduced

TUBEX cartridge-needle units are pre-sterilized; the needles pre-sharpened. This means that Central Supply can turn its attention to duties other than the time-consuming sterilization of syringes and the sharpening and sterilization of needles. It also means that breakage, which invariably accompanies these operations, and which raises the hospital's costs, is drastically reduced.

5. A source of hepatitis eliminated
6. Contact sensitization minimized

TUBEX cartridge-needle units serve for a single injection only. There can be no contaminated needles to transmit serum hepatitis or other diseases. Also, because there is virtually no chance for spillage, the nurse rarely comes into contact with drugs that might produce dermatitides or be absorbed to cause even more serious effects.

7. Inventory control simplified
8. Narcotic security tightened

The TUBEX system requires only two parts, half as many as the "conventional" system.

TUBEX System: cartridge-needle unit, syringe
Conventional System: plunger, barrel, needle, medication

There are fewer records to keep. Inventory control, therefore, is more accurate and efficient. As inventory control becomes more accurate, narcotic security automatically tightens.

9. Patients react more pleasantly to injections
10. Most commonly used drugs available

The most obvious direct benefit that the TUBEX system provides for the patient is a relatively painless injection, the result of a fresh, pre-sharpened, single-use needle. Since most common drugs—and many uncommon ones as well—are available in TUBEX form, the majority of hospital patients can benefit from the TUBEX system.

11. Accounting made more efficient
12. Billing made more accurate

Since each cartridge-needle unit contains a single, pre-measured dose, the amount of medication, including narcotics, that is given a patient is readily ascertainable. Hence, accounting is facilitated and the proper charges to the patient can be made accurately and easily.

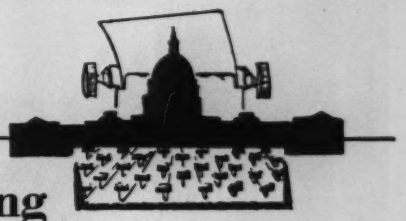
In summary

As you can see, adoption of the TUBEX system can have far-reaching effects. Efficiency and morale of the staff are improved. Labor costs—currently about 70 cents of every dollar spent by the hospital—are markedly reduced. Accounting, billing, and inventory control are made more accurate. The risk of malpractice suits is mitigated. The well-being of patients is enhanced.

The TUBEX system can presently supply more than 75 per cent of injectables commonly administered in hospitals. And medications not yet available in TUBEX form can be administered by means of empty, sterile cartridge-needle units. Thus, the TUBEX system is capable of meeting every need for injectables.

The TUBEX system is already in wide use. To learn more about the many benefits that the TUBEX system can bring to *your* hospital, please see your Wyeth Territory Manager or write to Wyeth Laboratories, P.O. Box 8299, Philadelphia 1, Pa.

WASHINGTON REPORT



Forand Bill No Solution: Flemming

Hearings on the Forand bill drew attention of the health field last month. The bill, named after Rep. Aime J. Forand (D-R.I.) who first introduced it in 1957, represents an amendment to the Social Security Act. The amendment would provide for the purchase of certain health care services for social security beneficiaries by the federal government. The strongest argument in favor of the bill has been that it would provide a method to take care of the health needs of the aged.

Under the terms of the bill, the government would contract for the services of hospitals, nursing homes, physicians and dentists.

Five-day hearings on the Forand amendment began July 13 before the House Ways and Means Committee. Prior to the hearings, Representative Forand stated that even though organized medical groups will oppose the bill as "socialism," he expected the hearings to develop medical testimony demonstrating that the bill can be administered satisfactorily.

The lead-off witness for the administration was Arthur S. Flemming, secretary of Health, Education, and Welfare. Secretary Flemming, while recognizing the problem of providing health care for the aged, opposed H.R. 4700, saying, "We do not believe that H.R. 4700 provides a satisfactory solution to the problem." He asked the committee for further time to study other approaches to providing health care for the aged, and promised the committee his personal attention would be given to finding alternatives to the Forand bill.

Secretary Flemming summarized the administration's stand on health care for the aged under five points:

1. The administration must come to grips with the problem of providing adequate hospital care for the aged.

2. The percentage of aged persons covered by hos-

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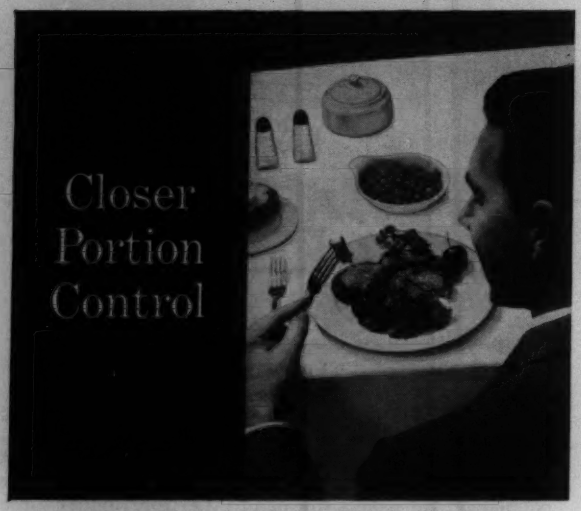

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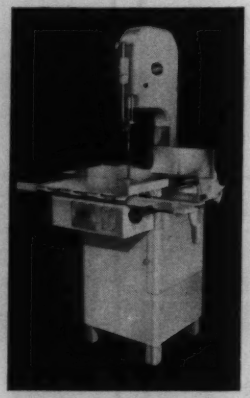

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pital insurance written by nonprofit groups and insurance companies has increased in a very significant manner in recent years.

3. There is every indication that the percentage of aged persons covered by hospital insurance written by nonprofit groups and insurance companies will continue to increase.

4. The enactment of a compulsory hospital insurance law would represent an irreversible decision to abandon voluntary insurance for the aged in the hospital field and would probably mark the beginning of the end of voluntary insurance for the aged in the health field generally.

5. Instead of abandoning voluntary hospital insurance for the aged in favor of compulsory insurance, every possible effort should be made to determine whether or not a plan can be developed that will strengthen the voluntary approach by making adequate protection available to a larger percentage of the aged.

In answer to committee questions, Secretary Flemming said the estimated first year (1960) cost of Forand bill would be a little over a billion dollars.

Another notable first-day witness was Dr. James P. Dixon, who appeared before the committee on behalf of the Hospital Council of Philadelphia. Dr. Dixon testified in favor of the principles of H.R. 4700 and called for its speedy enactment.

He said, "It is our view that the pattern for national participation in problems of health and welfare of the aged has been firmly established in the OASDI (social security) mechanism. We are of the belief that the extension of the OASDI program to include hospitalization benefits presents a logical solution to this most pressing problem. We are aware that this approach will create new relationships for the hospitals and will require legislative safeguards, but the design of safeguards should not act as a deterrent to the speedy enactment of such legislation."

Recommend Labor Act Exemption

Exemption of nonprofit hospitals from provisions of the Fair Labor Standards Act was continued by action of the Senate Labor Subcommittee headed by John F. Kennedy (D-Mass.)

The Kennedy subcommittee, by voice vote, approved legislation which would bring millions of new employees under both minimum wage and maximum hour provisions of the Fair Labor Standards Act.

But nonprofit hospitals would continue to be exempt. An outline of Senator Kennedy's Wage and Hour Act amendments, as reported out to the full committee on July 10, disclosed provisions affecting establishments which are operated by some hospitals.

These include some pharmacies, restaurants or coffee shops, gift shops or parking lots, which would come under the retail-service category, as well as laundries and drycleaning establishments operated as separate entities. The provisions for these two categories, as included in the Kennedy amendment, would be as follows:

Retail—Service

(a) All employees in enterprises effecting commerce (about 6.8 million) would receive a minimum of $1 an hour on effective date. No overtime provisions for those employees in enterprises with less than $750,000 gross sales were included.

(b) Employees in enterprises with more than

$750,000 annual gross sales would increase hourly wage and decrease straight time hours on the following scale: first year of service, $1, 46 hours; second year, $1.10, 44 hours; third year, $1.20, 42 hours; fourth year, $1.25, 40 hours.

Laundries and Drycleaning Establishments

All employees in enterprises effecting commerce, would have minimum wages of $1 an hour on effective date, but no limit on hours. For enterprises with annual sales volume of $250,000 or more or those doing 15 per cent commercial work, wages and hours would be set according to the same scale as retail-service noted above.

Nurse Traineeship Program Extended

Congress has extended for five more years the federal traineeship awards to professional nurses.

The program, which has used $5 million annually in federal funds over three years, received congressional authorization for an additional $6 million a year. Whether Congress will appropriate all of this sum each year remains to be seen. The Eisenhower administration is expected to request considerably less than the $6 million authorization for the current fiscal year, 1960.

Rep. William H. Avery (R-Kan.) predicted that the federal traineeship program "will probably become permanent". He noted that frequently "a good program", proposed originally to Congress as temporary, later wins permanent status.

During the first year of the program, three years ago, 56 schools provided training under the federal awards. In the current year, the number of participating schools jumped to 88. The number of nurses receiving awards totaled 838 in the first year. This number has increased to 1966.

Advanced Nurse Training Announced

Following passage by Congress of the professional nurse traineeship program, Public Health Service's Division of Nursing Resources announced a new program of short-term traineeships for nurses in supervision and administration.

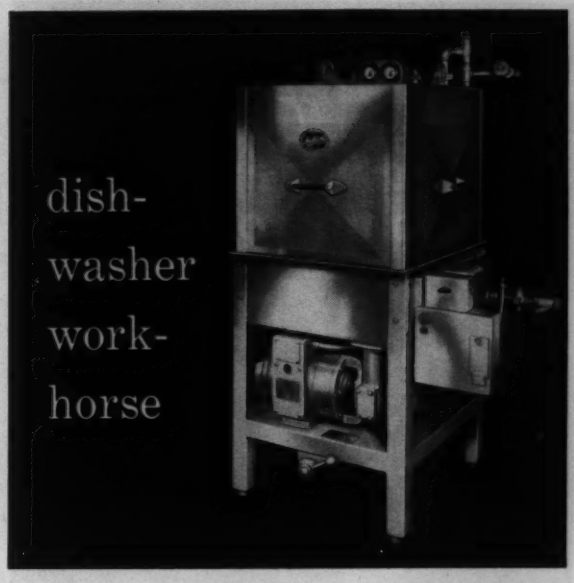
The traineeships will be awarded to graduate professional nurses for whom advanced full-time study is not now possible.

Institutions or agencies providing the training will employ qualified nurse faculty and present the plan for the course to the Public Health Service for approval. Other details of the criteria for participation in the short-term traineeship program will be announced by the service at a later date.

New Construction Legislation Proposed

Following the presidential veto of the Omnibus Housing Bill, HEW Secretary Flemming proposed that the college housing loan program be taken out of that major bill and considered on its own merits, "... unencumbered by consideration of other specialized housing programs." This program was one of three included in the omnibus bill of concern to hospitals.

Secretary Flemming proposed a new college housing loan program that would include hospitals as an eligible category for the construction of dormitories for student nurses and medical interns.



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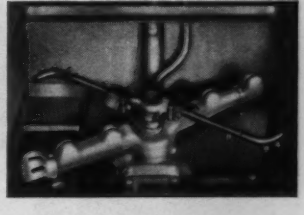

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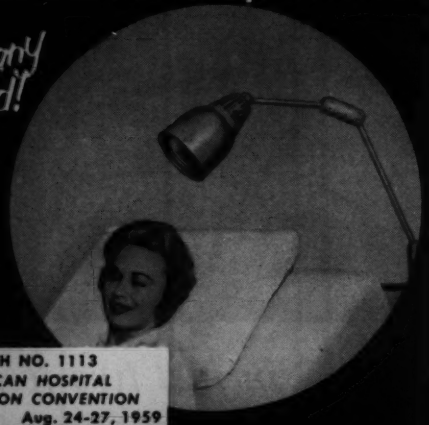

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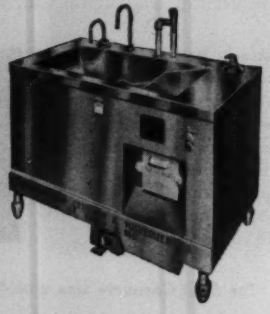

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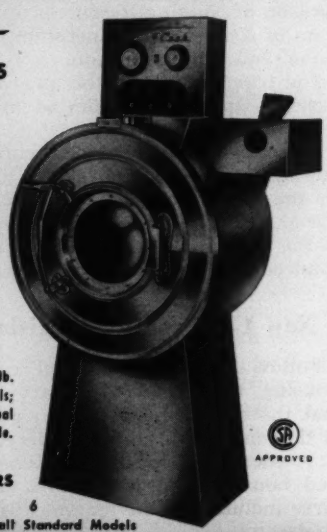

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AT HOSPITAL-BLUE CROSS RELATIONS CONFERENCE—

Greater Coverage Depth Seen as Main Goal

Insurance programs should provide coverage of a larger portion of the nation's health bill.

Blue Cross plans should experiment with new forms of coverage.

Blue Cross should not become too similar to commercial insurance companies.

Only the government can provide for certain health needs of the nation.

These were some of the contentions voiced at the National Conference on Hospital-Blue Cross Relations held at the Chicago headquarters of the American Hospital Association, July 6-7. Speakers at the conference represented the government, the press, the hospitals, and the public at large.

"Among the deficiencies in American health insurance programs, none is of greater cogency than their failure to cover a larger portion of the nation's health bill," said New York State Senator George R. Metcalf.

75 PER CENT PAID OUT OF POCKET

Quoting Irving Baldinger, writing in a State of New York Department of Labor publication, Senator Metcalf pointed out that health insurance provides less than 25 cents of every dollar spent on medical care, and that the remaining 75 cents is paid out of pocket. The medical care referred to included all services, such as dental and nursing, and drugs.

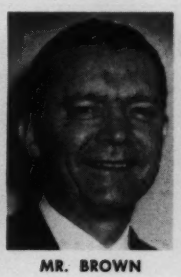
The senator argued that the statistics showing increasing number of people covered are misleading if taken to indicate that the *amount* of medical care coverage is growing correspondingly. He cited the need for studies to determine the essentials of really adequate medical care and the methods of covering care needs.

Mr. Metcalf was seconded in these arguments by George Bugbee, president of Health Information Foundation, New York. Mr. Bugbee said that benefits were the important consideration and that they should not be overshadowed by the mechanisms of providing prepayment. He also stressed the importance of assuring the public that what it is paying for is well worth the cost. Referring to the degree of coverage, Mr. Bugbee indicated that if families and individuals should be "protected" against only 40 to 50 per cent of their medical expenses, higher, rather than lower, costs would be the consequent aim.

NEW FORMS OF COVERAGE

Coverage experimentation had its chief proponent in Jerome Pollack, program consultant of the Social Security Department, International Union of the United Auto Workers, Detroit. The long-term hope of the voluntary plans, he stated, was to maintain a broad base of sharing risks, and to extend a broad spectrum of benefits both for minor and major medical services.

MR. BUGBEE



MR. BROWN

Another tack was taken on this point by Ray Brown, superintendent of the University of Chicago Clinics, who said that Blue Cross should remain Blue Cross, instead of adopting insurance company methods. He referred in particular to the deductible contracts and merit rating methods some plans have recently introduced.

"Blue Cross plans and commercial plans might become so similar," Mr. Brown said, "that the American public would not have a choice."

Both Mr. Pollack and Mr. Brown expressed concern over the close relationship between hospitals and Blue Cross as seen by the public.

Mr. Pollack expressed the belief that the close tie between these two groups was one of the conditions that invited public investigation.

Mr. Brown warned that the separation of Blue Cross and hospitals should take place to the extent of permitting Blue Cross to be the consumer's representative. Referring to the plans' board memberships, he pointed out that Blue Cross is controlled by hospitals "and the public will not tolerate the umpire playing on the team."

GOVERNMENT'S ROLE

That the government alone can perform certain functions in the health and prepayment fields, and that cooperation in these areas is necessary and desirable appeared to be a point of agreement between Senator Metcalf and Kenneth Williamson, director of the Washington Service Bureau of the AHA.

Legislators recognize that the role of the federal government is to supplement, not to supplant, the voluntary hospital and prepayment system Mr. Williamson said. Government help must be accepted where it is needed—in research, nursing and medical training centers, and in indigent care, he said. This will free the paying patient from the burden of these costs, Mr. Williamson pointed out.

MR. WILLIAMSON

The AHA Washington Bureau chief said that when the public strongly feels the need for action and that action does not come from local and state governments, the federal government takes steps. He also expressed the warning, repeated by many of the other speakers, that more of the early experimental community spirit must be awakened in the Blue Cross-hospital field. The common point of view, he said, is that hospitals are not run efficiently, that someone is making money, and that there is more preoccupation with the prepayment and hospital reimbursement mechanisms than with

the health needs of the people.

"Government has a huge role to play both as advocate and critic," stated Senator Metcalf. He suggested the government fulfill these functions by—

- Offering Blue Cross plans the opportunity to state their cases in a public forum through public hearings;
- Supplying funds for research —as in the case of the experimental program conducted by Group Health Insurance of New York City this year to ascertain the feasibility of including 30 days of hospital care for mental illness and outpatient psychiatric treatments;
- Examining the records of hospitals, physicians and other providers of hospital care to determine true costs and to study the Blue Cross reimbursement formulas and the hospital charges. ■

Los Angeles Area Plans Major Hospital Growth

A long-range hospital planning program has been approved for the Los Angeles metropolitan area by the State Hospital Advisory Council of California.

The state council recommended the construction of hospitals with a capacity of at least 150 beds, rather than the building of many smaller hospitals.

Planning of construction or expansion of hospitals was based on an anticipated population increase of 66 per cent. By 1975, the population of metropolitan Los Angeles is expected to reach 12 million.

The program has received the endorsement of the Hospital Council of Southern California and the Welfare Planning Council of the Los Angeles Region. ■

Southern California Hospitals Join In Program for Uniform Charge Bases

A program designed to achieve uniformity in the method and basis of establishing hospital charges in relation to cost was launched last month in Southern California.

The program is based on "guiding principles" adopted by the Hospital Council of Southern California and its eight area councils. It is founded on about three years of study supported by various community and professional groups—hospital and medical people, insurance companies and Blue Cross, union and welfare groups.

The guiding principles, or code, will not establish prices nor guarantee that all hospitals will charge the same prices, according to John P. Preston, president of the council and administrator of Inter-Community Hospital at Covina. "Labor costs and other factors in various parts of Southern California will mean price differences," Mr. Preston said, "but the plan will establish a standard system for charges. It will help the patient understand hospital bills and give an opportunity to compare costs for similar care in hospitals within the same area."

Under the program, each participating hospital develops its own schedule of charges, based on local costs, to which it must adhere.

Each hospital must have its schedule of charges on display at the front desk, where it may be examined by anyone wishing to do so. The schedule is made up in loose leaf book form.

By mid-July, hospitals participating in the program numbered 135. They represented about 95 per cent of the council member beds, and 78 per cent of all the hospital beds of all types in Southern California, which total approximately 16,000.

COMPOSITION OF CHARGES

The council's code incorporates specific composition of basic charges for hospital services, divided into eight categories. The categories follow, together with a brief summary of charges included in each:

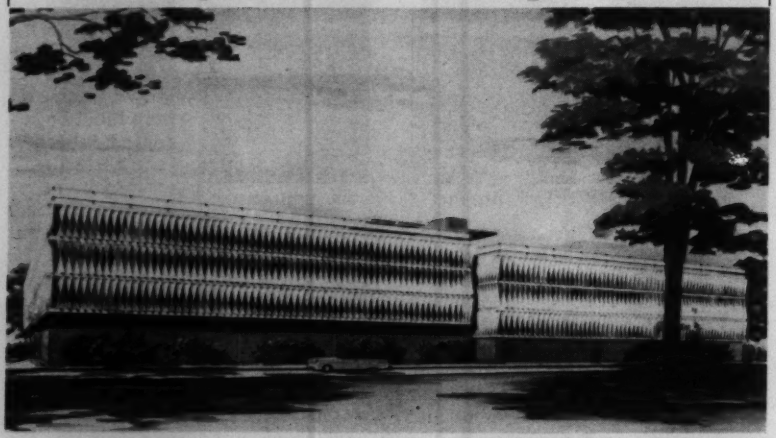
1. Daily Hospital Service. It includes room, linen service, meals, nursing service, medical records, admitting service, use of hospital equipment and instruments used in patient examinations, simple drugs and routine supplies, administration of medications, simple laxatives and similar services.

2. Pharmacy. It includes cost of prescribed drugs and services of pharmacy personnel.

3. Central Service. It includes the cost of supplies and the cost of their preparation, handling and storing.

4. Operating Room Service. The charge is based on amount of time the patient is in the operating room

Parking Structure for Hospital Staff



Architect: Albert Kahn Associated Architects and Engineers, Inc.

PARKING STRUCTURE (front view) for the Henry Ford Hospital, Detroit, is shown in an architectural rendering prepared by the designers. The building will serve 870 cars.

Parking problems of the staff of Henry Ford Hospital, Detroit, will be solved this year with the completion of a five-story, self-parking structure which will provide space for 870 cars.

The open-deck, split-level building will incorporate materials similar to those used on the present hospital buildings but the structure will have modern appearance and construction features. Two passenger elevators and three sets of stairs will serve the patrons. Natural lighting will be provided by a skylight, thus eliminating the gloomy atmosphere typical of that type of building. A sculptural grille on the upper floors will hide the cars from outside view. ■

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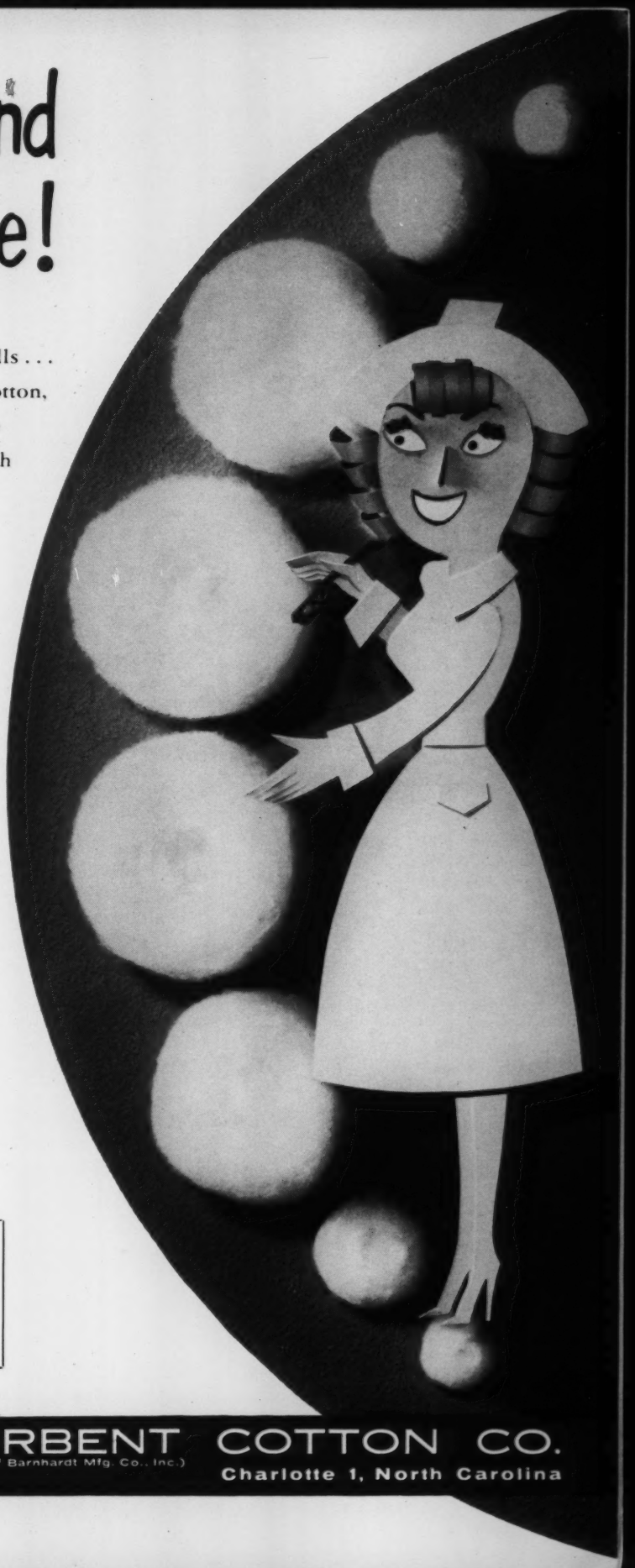

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and also on the type of operation. It includes recovery room services, and routine supplies such as sutures.

5. Delivery and Labor Rooms Service. This is a flat rate charge.

6. Professional Services. The code recommends this fee be assigned by the medical specialist to the hospital for collection.

7. Blood Transfusions are considered a service and not a sale. Laboratory work, such as typing, is handled as other laboratory charges, included in Category 6. Costs of storage, handling, and administration of blood are grouped, and a single administration charge is made.

8. Personal Items. These include telephone calls, guest meals, personal drugs, and are charged separately.

OPERATING ETHICS

In addition to establishing the composition of basic charges for hospital services, the guiding principles aim at standardization of hospital operating ethics. In addition to hospital charges, the code covers such subjects as objectives of the hospital, duties of governing board, organization of medical staff, and admitting procedures.

Principles to be followed by hospitals in operating ethics are also recommended. These incorporate principles approved and presented by the American Hospital Association in 1956 and revised in June 1957.

"Only services ordered by the attending physician or routine procedures established with the approval of the medical staff are charged to the patient. The hospital does not include charges for professional services rendered by physicians or special duty nurses; these may be billed separately by the person providing the services or by the hospital acting as billing agent," the code states.

An eight-member grievance committee has been established in conjunction with the program. It is headed by Samuel J. Tibbitts, superintendent of California Hospital, Los Angeles. The committee will consider complaints from patients, physicians, insurance companies and other groups regarding infractions of the ethics code, thus providing a means of enforcing compliance by the hospitals. ■

Correction

Due to an error, a photograph on page 20 of the July 1 issue of this Journal was incorrectly captioned. The picture showed Dr. Leonard W. Larson, not Dr. John S. DeTar, as was indicated. ■

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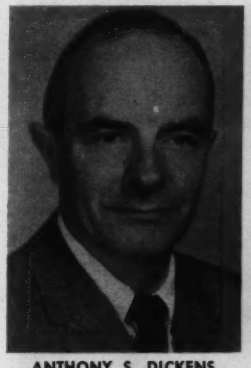

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Groups Elect Officers

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Connecticut Hospital Association: president, Charles T. Treadway Jr., president, Bristol Hospital; president-elect, Richard O. West, administrator, Norwalk Hospital; treasurer, William G. Boies, trustee, Waterbury Hospital.

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Louisiana Hospital Association: president, Billy W. Brown, administrator, Homer Memorial Hospital; president-elect, Dr. W. Rigsby Hargrove, owner, Hargrove Clinic and Hospital, Oakdale; vice president, Mother Marie Blanche, administrator, Terrebonne Parish General Hospital, Houma.

Hospital Council of Maryland, Inc.: president, Dr. Edward Stinson Jr., Union Memorial Hospital, Baltimore; vice president, Robert S. Hoyt, administrator, Lutheran Hospital of Maryland, Baltimore; treasurer, Sister Pierre, O.S.F., administrator, St. Joseph's Hospital, Baltimore.

North Carolina Hospital Association: president, Edward R. Frye, administrator, Good Samaritan Hospital, Charlotte; president-elect, J. E. Barnes, director, Rex Hospital, Raleigh; secretary-treasurer, J. Minetree Pyne, administrator Alamance County Hospital, Burlington.

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Hospital Council of Lackawanna County: president, Mortimer B. Fuller Jr., president, Hahnemann Hospital, Scranton, Pa.; first vice president, Judge T. L. Hoban, director, Mercy Hospital, Scranton; second vice president, Sister M. William Joseph, R.S.M., administrator, Mercy Hospital, Scranton; secretary, Peter J. Lynott, director, St. Mary's Hospital, Scranton; treasurer, David S. Vipond, delegate, Lackawanna United Fund.

Hospital Council of Philadelphia: chairman, Clarence A. Warden Jr., Wynnewood, Pa.; first vice president, Robert V. Bolger, Philadelphia; second vice president, Morris Cheston, Philadelphia; secretary, Brandon Barringer, Curtis Publishing Co., Philadelphia; treasurer, I. Melville Stein, Philadelphia.

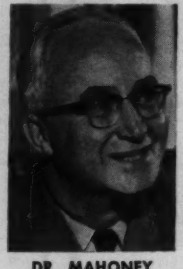
Twin City Regional Hospital Council: chairman of the board, Kenneth Holmquist, superintendent, Bethesda Hospital, St. Paul; vice chairmen, Jack W. Rivall, administrator, Doctors Memorial Hospital, Minneapolis, and L. M. Conley, director, United Baptist Fund, (operating Midway and Mounds Park Hospitals) St. Paul; secretary, Mrs. Helen Rosenwald, administrator, St. Luke's Hospital, St. Paul; treasurer, Russell C. Nye, administrator, Northwestern Hospital, Minneapolis. ■

AHA Appoints Mahoney and Schmidt

Dr. James A. Mahoney has been appointed assistant director of the Department of Professional Services and secretary to the Committee on Infections within Hospitals of the Council on Professional Practice of the American Hospital Association, it was announced by Dr. Edwin L. Crosby, director of the Association. Dr. Mahoney will assume his position with AHA early this month.

Prior to accepting his present position, Dr. Mahoney was group captain, Royal Canadian Air Force and commanding officer of the R.C.A.F. Hospital at Rockcliffe, Ont.

Dr. Mahoney began his professional career in 1933 after receiving his M.D. degree from the University of Toronto. In 1940 he received a Rockefeller Foundation



DR. MAHONEY

MR. SCHMIDT

fellowship to return to the University of Toronto, where he then obtained a doctor of public health degree. In 1941, Dr. Mahoney embarked on a career with the R.C.A.F., which he interrupted in 1952-54 to work toward a master of science degree in hospital administration at Columbia University. He interned at Roosevelt Hospital in New York.

Dr. Mahoney is member of American College of Hospital Administrators, American Public Health Association and Aero-Medical Association. He is a fellow of American College of Preventive Medicine and American Board of Preventive Medicine.

The appointment of William S. Schmidt to the staff of the American Hospital Association, effective August 1, has also been announced by Dr. Crosby.

Mr. Schmidt will be secretary to two AHA Committees: Committee on Hospital Organization and Committee on Methods Improvement in Hospitals. His responsibility will be in the areas of methods improvement and development of organizational techniques in hospitals.

Mr. Schmidt is currently administrative assistant at Grace-New Haven Hospital, New Haven, Conn. He graduated from the University of Michigan program in hospital administration, then served his residency with Dr. Albert Snoke, director of Grace-New Haven Hospital. The American College of Hospital Administrators awarded Mr. Schmidt the Mead-Johnson scholarship. ■

Court in Washington Rules On New Minimum Wage Law

When a new minimum wage and hour law went into effect in the state of Washington in June, it soon appeared doubtful that all the provisions of the law would be enforced. Employer groups in the state immediately began legal action designed mainly to test the application of the law.

The first indication as to enforcement of the law came from Thurston County Superior Court Judge Charles T. Wright. The judge upheld the $1 an hour minimum wage and other sections of the law. But he held that the overtime provisions were unconstitutional and also ruled invalid the section giving the director of the Department of Labor and Industries authority to make rules and regulations.

On the provisions calling for time and a half pay for work in excess of 8 hours a day and 40 hours a week, the judge ruled that it restricted the freedom of contract between employers and employees.

The other provision was held invalid because it did not contain sufficient guides and standards for the director to follow.

Judge Wright's decision was appealed in the state supreme court. That court's decision, expected early this fall, will determine which provisions of the new law can be enforced by the state. ■

Insurance Program Extends To Eighth Canadian Province

New Brunswick this summer became the eighth province to enter into a compulsory hospitalization insurance program financed half

and half by the federal and provincial governments.

The plan will provide comprehensive hospitalization coverage for every resident of the province and will be operated by a Hospital Services Commission, as outlined in the agreement New Brunswick made with the Dominion government under the Hospital Insurance and Diagnostic Services Act.

In addition to the inhospital services required by the act, the New Brunswick plan includes a broad range of outpatient services, such as laboratory, and emergency as well as rehabilitative diagnosis and treatment.

Speaking at the agreement-signing ceremony for the Dominion government, J. Waldo Monteith, minister of National Health and Welfare, commented on the tremendous value the hospital insurance program has had in other parts of Canada.

With New Brunswick's entry, the hospital insurance program now encompasses all but two provinces. On July 1, 1958, British Columbia, Alberta, Saskatchewan, Manitoba and Newfoundland began operations, and on January 1, 1959, plans in Ontario and Nova Scotia came into being. ■

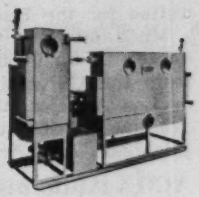
General Hospitals Report On Treatment of Mentally Ill

Treatment of mentally ill given in psychiatric sections of three general hospitals has brought improvement in 80 per cent of the cases, according to a report from Georgia. About 230 patients, living near the hospitals, have been admitted under this new intensive treatment program launched by the state and paid for by the state's health department. Nearly 300 patients from 79 counties have been approved for treatment.

Results of the treatments were given in an annual report of the Georgia Department of Public Health. The department's mental health division, headed by Dr. Trawick Stubbs, supervises the program.

In addition to hospital treatment, the Georgia project provides for follow-up of the patients through outpatient services, vocational rehabilitation and continued care under the supervision of the patient's family physician.

Mental health leaders have hailed this program as one of the measures for reducing the number of patients needing admission to the state mental hospital. They



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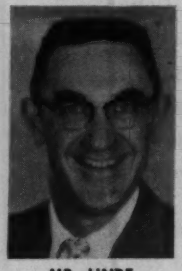
contend that long-term hospitalization can be avoided often if patients receive intensive short-term treatment early in their illness. ■

Accounting Research Grant To Aid Smaller Hospitals

The Hospital Research and Educational Trust has received an $81,890 grant from the W. K. Kellogg Foundation for the purpose of helping smaller hospitals improve accounting procedures, according to Dr. Edwin L. Crosby, director of the trust.

Dr. Crosby also announced the appointment of Robert E. Linde to the position of the trust's regional project director, Hospital Administrative Services, Lincoln, Nebr.

The grant from the Kellogg Foundation, Dr. Crosby said, will finance the Hospital Administrative Services project of the trust until July 1, 1960, in a three-state area of Colorado, Nebraska, and South Dakota. The general purpose of the project will be to provide better financial and statistical information to hospital administrators and trustees of smaller hospitals to aid them in making management decisions.



MR. LINDE

MR. TRANER

In his announcement of the grant, Dr. Crosby referred to another grant, received in February. That grant, he said, financed a pilot study which had verified the practicability of central preparation of accounting and statistical reports for hospitals.

That pilot study, Dr. Crosby commented, had served as a basis for the development of a simplified accounting system that provides the necessary financial and statistical information, yet requires only a minimum amount of accounting knowledge.

LINDE APPOINTMENT

Mr. Linde, who will be regional director of the program in the three-state area, came to Lincoln from the University of Texas, Austin, where he was assistant professor of accounting. At Austin, he also served as treasurer and member of the Board of Child and Family Service, Inc.

In 1956, Mr. Linde was employed by the American Hospital Association to assist in the preparation and writing of the manual, *Cost Finding for Hospitals*. He later served as member of the AHA Subcommittee for the Budgeting Manual.

Mr. Linde received his master's degree in business administration from the University of California at Los Angeles, then did further graduate work at the University of Michigan, Ann Arbor. ■

ACHA Appoints Traner New Admissions Director

Dan Traner of Lynn, Mass., took office last month as the new director of admissions for the American College of Hospital Administrators. Dean Conley, executive director of the college, made the announcement.

Mr. Traner will handle admissions of new members and affiliate advancements to higher status within the college.

Until 1958, when he retired, Mr. Traner was for 21 years administrator of Lynn (Mass.) Hospital. He had also served as president of the Massachusetts Hospital Association and as director of the Massachusetts Blue Cross.

In 1945, Mr. Traner was appointed by the governor of his state to an advisory committee on hospitals and health centers. He has been an active member of ACHA since 1934, and in 1940 attained fellowship, the highest professional status. ■

Legislative Notes

Colorado—Employees of hospitals and other charitable organizations are now covered by unemployment compensation. The bill that repealed a section of law denying unemployment benefits to this group was signed by the governor last May, and the changed law went into effect July 1. The nonprofit employers must now pay a tax to support the new service.

Connecticut—That each town provide necessary hospitalization to welfare patients has been clarified in an act which repealed and substituted certain sections of general statutes, effective July 1.

The statutes previously provided for medical care, without specifying hospitalization. The act further establishes as a test for eligibility for hospitalization at town expense the patient's ability to pay for hospitalization "over a reasonable period of time," removing the requirement that the person actually be adjudged a "pauper."

The town's obligation to provide hospitalization starts at the time of admission if the hospital gives the town notice within three business days of the beginning of hospitalization.

Towns may elect on an annual basis whether they wish to pay for special services at the average rate established by the hospital cost commission or pay actual charges. The commissioner of welfare will arbitrate disputes between hospitals and towns.

Three Americans Receive Florence Nightingale Medal

Three American women this year received the Florence Nightingale Medal of the American Red Cross. The award is made by the International Committee of the Red Cross "to honor nurses and voluntary aides who have distinguished themselves exceptionally by their devotion to the sick or wounded in war or in peace."

A total of 36 medals may be awarded every two years to candidates selected all over the world on recommendations from Red Cross societies. Only three persons were honored this year.

The recipients of the medal were: Mrs. Lucille Petry Leone, chief nurse officer, Office of Surgeon General, Public Health Service, Washington, D.C.; Miss Ruth Sleeper, director of nursing service, Massachusetts General Hospital, Boston, and Miss Effie J. Taylor, now retired, who had previously been dean of the Yale University School of Nursing.

E. Roland Harriman, chairman of the American Red Cross, made the award presentations. ■

State Medical Society Plans Hospital Service Awards

Three hospitals in Wisconsin will receive "community hospital service" awards annually from the State Medical Society of Wisconsin.

Small, medium-sized and large hospitals which have demonstrated achievement in improved facilities, service or expansion of their over-all usefulness to the community will be selected.

In announcing this plan, Dr. William B. Hildebrand, president of the society, said: "Community hospitals receive all too little credit for the remarkable service they provide to the sick and injured

and to the entire community . . . During this week of recognition for hospitals, May 10-16, the public should join physicians in taking their hats off to the progress of our Wisconsin hospitals . . . It takes a lot of heart along with the brick and beds to provide adequate hospital care . . ." ■

Ruth Heinemann Becomes President of ASMT

Ruth Heinemann took office as president of the American Society of Medical Technologists at the society's annual convention last month.

Miss Heinemann is medical laboratory consultant with the Minnesota Department of Health on the Hospital Services Demonstration Study. For the study, she has conducted a survey of clinical laboratories in Minnesota general hospitals. For many years, she served as student technologist supervisor in clinical chemistry at the University of Minnesota Hospitals, Minneapolis. From 1955 to 1958, Miss Heinemann was co-chairman of the Civil Service-Armed Services Joint Committee which participated in the preparation of classification and qualification standards at professional levels for medical technologists. ■

HEW Names Roudebush Director of Aging Council

Warren T. Roudebush has been named executive director of the Federal Council of Aging by Arthur S. Flemming, Secretary of Health, Education, and Welfare. Mr. Roudebush has been assistant to the director of personnel of HEW since 1957. ■

Frances Peterson Succeeds Mildred Schwier at NLN

Frances K. Peterson has been appointed director of the National League for Nursing Department of Diploma and Associate Degree Programs. She succeeds Mildred E. Schwier who will become director of the School of Nursing and Nursing Service at Rhode Island Hospital, Providence, on November 1.

Miss Peterson was since 1952 assistant director of the NLN department. Before joining the league in that year, she held various posts in hospital and public health nursing, and nursing education. She graduated from St. Vincent's Hospital School of Nursing and has been head of the outpatient department at that hospital. She re-

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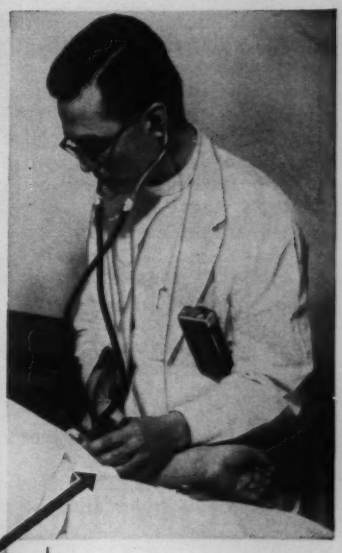

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Every month, more hospitals are finding that a Motorola Radio Paging system gives them *instant, positive, private* contact with key personnel. Take Chicago's St. Anthony dePadua Hospital. It has 30 Radio Pagers in use now, with plans for a total of 55. Sister Maristella, O.S.F., Administrator, says, "Personnel are notified faster, they respond more quickly, so service and attention can be given more swiftly."

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ceived her master's degree in nursing education from Catholic University, Washington, D.C.

Miss Schwier was director of nurses at Mount Vernon (N.Y.) Hospital before joining NLN. She graduated from that hospital's school of nursing, and received her master's degree from Teachers College, Columbia University. ■

N.C. Blue Cross Extends Coverage to Elderly

Blue Cross coverage on an individual basis for persons over 64 has been made available in North Carolina.

E. M. Herndon, executive vice president of Hospital Care Association, the state's plan, said in making the announcement that the new "senior citizen" plan will enable many thousands to get "reliable low-cost protection against the hospital and medical care expenses they are almost sure to have with advancing age." They were previously ineligible for Blue Cross because they failed to get coverage before they were 65.

The program has been approved by the North Carolina insurance department. Benefits provided by the new certificate include inhospital care for up to 31 days, automatically renewed after 90 days out of the hospital; a $150 maximum surgical schedule; inhospital medical benefits for 30 days; certain therapeutic and outpatient services, and diagnostic x-ray and laboratory examinations in physicians' offices or hospitals. The cost is $18 quarterly for one person.

"Applicants will be required to fill out and sign a health questionnaire. Anyone 65 or over and in reasonably good health will be accepted," Mr. Herndon stated. ■

Two Health Groups Announce New Addresses

Two organizations in the health and hospital field moved recently to new headquarters.

Joint Commission on Accreditation of Hospitals announced that its new address is 200 East Ohio Street, Chicago 11.

Joint Commission on Mental Illness and Health announced that its mail should be addressed c/o Massachusetts Mental Health Center, 74 Fenwood Road, Boston 15. ■

1959 hospital administrative residents

Following is a listing of students who have completed their classroom work in hospital administration and been assigned to residencies. This is a continuation of a listing begun in the July 16 issue of this Journal.

BAYLOR UNIVERSITY WITH ARMY MEDICAL SERVICE SCHOOL residents are, (from left) top row: Maj. John J. H. Connors (Canada); Maj. Philip L. LaManche; Maj. Raymond K. Mortensen; Capt. Maurice G. Winstead; Maj. Walter P. McHugh; Lt. Col. Frank D. Godwin; Maj. William P. Chambers; Lt. Col. Frank K. Lawford; Maj. Martin Zachar Jr.; Capt. Aaron Ryan; Capt. Hazel L. Green Jr.; Lt. Col. Eugene T. Brown. Second row: Lt. Col. Floyd L. Berry; Capt. Michael D. Guerin Jr.; Col. Pradist Tuchinda (Thailand); Capt. William B. Neubrand; Maj. Henry J. Rockstroh; Maj. Carroll E. Clutter; Capt. Alan Harcus; Maj. Paul H. Myers; Capt. Adam E. Adams; 1st Lt. David B. Illsley; Capt. Donald B. Wagner; 1st Lt. Alfred C. Schiefer; Maj. Howard T. Cohen; Maj. Jung Sukhyun (Korea). Third row: Lt. Col. Hamaoka Sunao (Japan); Maj. Herman C. Needles; Maj. Shoja Hejazi (Iran); Maj. Arthur W. Barker; Lt. Col. A. G. Sheikh (Pakistan); Lt. Col. Robena C. Anderson; Capt. Barbara L. Kennon; Maj. Lillian Dunlap; Maj. Althea E. Williams; Maj. Miyasaki Toschio (Japan); Capt. Ray E. Van Cleave; Maj. Mario Tapia-Caballero (Chile); Lt. Col. James B. Miller; Lt. Col. Mohammad A. Khalaf (Jordon). Front row: Col. Glenn J. Collins; Maj. Dan G. Kadrovach (faculty); Mrs. Rose T. Migrelli (faculty); Lt. Col. Ralph G. LeMoon (faculty); Lt. Col. Albert B. Hunt (faculty); Col. Elwood W. Camp (faculty); Col. Raymond E. Duke (assistant commandant); Maj. Gen. Elbert DeCoursey (commandant); Col. William A. Hamrick (department director); Lt. Col. Gordon A. Jones (faculty); Lt. Col. Seth H. Linthicum Jr. (faculty); Lt. Col. Claude L. Hooker (faculty); Maj. Hasty W. Riddle (faculty); Maj. Richard C. Thompson (faculty); and Col. William O. Hastings.

BAYLOR UNIVERSITY WITH ARMY MEDICAL SERVICE SCHOOL

Course director: Col. William A. Hamrick

ADAMS, CAPT. ADAM E., to Valley Forge Army Hospital, Phoenixville, Pa.

ANDERSON, LT. COL. ROBENA C., to U.S. Army Hospital, Fort Hood, Texas.

BARKER, MAJ. ARTHUR W., to Germany.

BERRY, LT. COL. FLOYD L., to Fitzsimons Army Hospital, Denver.

BROWN, LT. COL. EUGENE, to Brooke Army Hospital, Fort Sam Houston, Texas.

CHAMBERS, MAJ. WILLIAM P., to U.S. Army Medical Service Historical Unit, Walter Reed Army Medical Center, Washington, D.C.

CLUTTER, MAJ. CARROLL E., to Korea.

COHEN, MAJ. HOWARD T., to Brooke Army Hospital.

COLLINS, COL. GLENN J., to U.S. Army Hospital, Fort Leonard Wood, Mo.

CONNORS, MAJ. JOHN J. H., from Canada.

DUNLAP, MAJ. LILLIAN, to Fitzsimons Army Hospital, Denver.

GODWIN, LT. COL. FRANK D., to Panama.

GREEN, CAPT. HAZEL L. JR., to Valley Forge Army Hospital, Phoenixville, Pa.

GUERIN, CAPT. MICHAEL D. JR., to Lackland Air Force Base Hospital, San Antonio.

HASTINGS, COL. WILLIAM O., Brooke Army Medical Center.

HARCUS, CAPT. ALAN, to Letterman Army Hospital, San Francisco.

HEJAZI, MAJ. SHOJA, from Iran.

ILLSLEY, 1ST. LT. DAVID B., to Chanute Air Force Base Hospital, Rantoul, Ill.

KENNON, CAPT. BARBARA L., to Walter Reed Army Hospital.

KHALAF, LT. COL. MOHAMMAD, from Jordan.

LAMANCHE, MAJ. PHILIP L., to France.

LAWFORD, LT. COL. FRANK K., to Germany.

MCHUGH, MAJ. WALTER P., to Lackland Air Force Base Hospital, San Antonio.

MILLER, LT. COL. JAMES B., to Madigan Army Hospital, Tocoma, Wash.

MORTENSEN, MAJ. RAYMOND K., to Madigan Army Hospital, Tacoma, Wash.

MYERS, MAJ. PAUL H., to William Beaumont Army Hospital, El Paso, Texas.

NEEDLES, MAJ. HERMAN C., to Walter Reed Army Hospital, Washington, D.C.

NEUBRAND, CAPT. WILLIAM B., to Wright-Patterson Air Force Base Hospital, Dayton, Ohio.

ROCKSTROH, MAJ. HENRY J., to Brooke Army Hospital.

RYAN, CAPT. AARON, to Walter Reed Army Hospital, Washington, D.C.

SCHIEFER, 1ST. LT. ALFRED C., to Keesler Air Force Base Hospital, Miss.

SHEIKH, LT. COL. A. G., from Pakistan.

SUKHYUN, MAJ. JUNG, from Korea.

SUNAO, LT. COL. HAMAOKA, from Japan.

TAPIA-CABALLERO, MAJ. MARIO, from Chile.

TOSCHIO, MAJ. MIYASAKI, from Japan.

TUCHINDA, COL. PRADIST, from Thailand.

VAN CLEAVE, CAPT. RAY E., to Carswell Air Force Base Hospital, Fort Worth, Texas.

WAGNER, CAPT. DONALD B., to MacDill Air Force Base Hospital, Tampa, Fla.

WILLIAMS, MAJ. ALTHEA E., to Germany.

WINSTEAD, CAPT. MAURICE G., to Carswell Air Force Base Hospital, Fort Worth, Texas.

ZACHAR, MAJ. MARTIN JR., to Letterman Army Hospital, San Francisco.

COLUMBIA UNIVERSITY

Course directors: Dr. Ray E. Trussell and Dr. Clement C. Clay

AVARD, PAUL F., to Nelson O. Lindley, administrator, Somerset (N.J.) Hospital.

BUFFINGTON, JAMES A., to Ed-

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COLUMBIA UNIVERSITY residents are, (from left) front row: Irwin Shapiro; Victor M. Pietri; Thomas P. Callaghan; Stephan L. Forstenzer; E. Harry Landbo; Dr. Abraham Rossman-Castilla; Hiram Yunquez-Martinez. Second row: Dr. Clement C. Clay (associate professor); Juan Rivera-Rivera; Arthur J. Jarvis; Raymond M. Jefferson Jr.; Marvin B. Klein; William G. George; James A. Buffington; Paul F. Avard. Third row: Dr. Lawson H. Bowling (psychiatric administration, not taking residency); Dr. William E. Schumacker (psychiatric administration, not taking residency); Maurice I. May; Harold Baumgarten Jr. (assistant professor); Hyman Cohen; Barry Kass (dropped out of program); Leonard Schrager; William A. Hurlburt, Otto E. Lynch; Robert L. Judy; Robert R. Reidy; Francis J. Murphy.

ward V. Grant, administrator, Hunterdon Medical Center, Flemington, N.J.

CALLAGHAN, THOMAS P., to Martin S. Ulan, administrator, Hackensack (N.J.) Hospital.

COHEN, HYMAN to William K. Klein, director, Long Island College Hospital, Brooklyn, N.Y.

FORSTENZER, STEPHEN L., to Elizabeth C. Berrang, R.N., director, Hospital of the University of Pennsylvania, Philadelphia.

GEORGE, WILLIAM G., to Dr. George Wm. Graham, director, Ellis Hospital, Schenectady, N.Y.

HURLBURT, WILLIAM A., to Frank P. Sauer, director, Muhlenberg Hospital, Plainfield, N.J.

JARVIS, ARTHUR J., to Robert P. Lawton, administrator, Danbury (Conn.) Hospital.

JEFFERSON, RAYMOND M. JR., to Dr. John N. Bowden, medical officer in charge, U.S. Public Health Service Hospital, Staten Island, N.Y.

JUDY, ROBERT L., to Dr. Ellsworth R. Browneller, medical director, Jefferson Medical College and Medical Center, Philadelphia.

KLEIN, MARVIN B., to Dr. Edward Kirsch, director, Lebanon Hospital, New York.

LANDBO, E. HARRY, to Dr. E. Dwight Barnett, administrator, Palo Alto-Stanford Hospital Center, Palo Alto, Calif.

LYNCH, OTTO E., to Dr. Kermit H. Gates, executive director, Jackson Memorial Hospital, Miami.

MAY, MAURICE I., to Harvey Schoenfeld, director, Barnert Memorial Hospital, Paterson, N.J.

MURPHY, FRANCIS J., to Harry C. F. Gifford, administrator, Community Hospital at Glen Cove, Long Island, N.Y.

PIETRI, VICTOR M., to Josue A. Colon, executive director, Bayamon (P.R.) District Hospital.

REIDY, ROBERT R., to Dr. Reo J. Marcotte, director, Mount Auburn Hospital, Cambridge, Mass.

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WASHINGTON UNIVERSITY residents are, (from left) front row: Marshall Maggard; Donald J. Horsh (associate director); Dr. Frank R. Bradley (director); Harry E. Panhorst (associate director); John Rice; Donald Nelson. Second row: Vincent Schneider; Roy Creech; Lt. John Hankins; George Banjak; Duane Houtz; Robert Blincow; Cecil Melville. Third row: Donald Dinger; Kenneth Hawthorne; Dr. Pierre Mercier; Richard Bogg.

RIVERA-RIVERA, JUAN, to Dr. Jaime Serra-Chavarry, manager, Veterans Administration Center, San Juan, P.R. (first six months); to Josue A. Colon, executive director, Bayamon (P.R.) District Hospital (second six months).

ROSSMAN-CASTILLA, DR. ABRAHAM, to Alfred E. Maffly, administrator, Herrick Memorial Hospital, Berkeley, Calif.

SCHRAGER, LEONARD, to Dr. Martin Cherkasky, director, Montefiore Hospital, New York.

SHAPIRO, IRWIN, to A. Rosenberg, executive director, Hospital for Joint Diseases, New York.

YUNQUE-MARTINEZ, HIRAM, to Josue A. Colon, executive director, Bayamon (P.R.) District Hospital.

WASHINGTON UNIVERSITY

Course director: Dr. Frank R. Bradley

BANJAK, GEORGE, to Jack A. L. Hahn, Methodist Hospital, Indianapolis.

BLINCOW, ROBERT, to Dr. Lee Cady, Veterans Administration Veterans Administration Hospital, Houston, Tex.

BOGG, RICHARD, to Albert Boulenger, Good Samaritan Hospital, Vincennes, Ind.

CREECH, ROY, to Willie Lourance, Memorial Mission Hospital, Asheville, N.C.

DINGER, DONALD, to Jack Shrede, Wesley Hospital, Oklahoma City.

HANKINS, JOHN, to Maj. Howard Colon, Scott Air Force Base, Belleville, Ill.

HAWTHORNE, KENNETH, to Allen M. Hicks, Pekin (Ill.) Public Hospital.

HOUTZ, DUANE, to Arthur Bailey, Orange Memorial Hospital, Orlando, Fla.

MAGGARD, MARSHALL, to Bryce Twitty, Hillcrest Memorial Hospital, Tulsa, Okla.

MELVILLE, CECIL, to Dr. Frank Groner, Baptist Memorial Hospital, Memphis, Tenn.

MERCIER, DR. PIERRE, to Dr. F. R. Bradley, Barnes Hospital, St. Louis.

NELSON, DONALD, to J. M. Crews, Methodist Hospital, Memphis.

RICE, JOHN, to Roy House, Wesley Hospital, Wichita, Kans.

SCHNEIDER, VINCENT, to Dr. F. R. Bradley, Barnes Hospital, St. Louis.

The law-in-brief

(Continued from page 101)

age of 70 she suffered a stroke and spent 14 months in the Jane

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See it at Booth No. 537, A. H. A. Show

O'Brien Hospital receiving primarily nursing care and the services of her own physician. The company denied the claim, protesting that the institution was not a hospital within the meaning of the insurance contract.

The policy required that the patient "be necessarily confined within a recognized hospital." It went on to define "hospital" as "an institution which has a laboratory, x-ray equipment and an operating room where major surgical operations may be performed, and which maintains permanent and full time facilities for the care of overnight resident patients under the supervision of a licensed Doctor of Medicine or Osteopathy and which has a Graduate Registered Nurse always on duty."

The institution concerned was licensed as a nursing home when the deceased was a patient. It met some of the above requirements but had no laboratory on the premises, and no operating room. These facilities were available nearby in the community.

The court concluded that the policy did not require all facilities to be maintained under the same roof or on the hospital premises. With regard to medical supervision, the court found the policy to be worded ambiguously; it was not clear whether the patient or the hospital need be under the supervision of a doctor. Since the insurance company drafted the policy, ambiguities would be construed against the company and in favor of the insured. As long as the patient was under the supervision of her own physician, a requirement of the policy was met.

The facilities of the institution were "in substantial compliance" with the policy requirements, in the opinion of the court, and the company was directed to make payment under the policies to the legal representatives of the deceased patient.

Hospital association meetings

(Continued from page 6)

19-22 **Staffing Departments of Nursing,** Minneapolis (Radisson Hotel)
19-23 ***American Occupational Therapy Association,*** Chicago (Morrison Hotel)
19-23 ***American Public Health Association,*** Atlantic City (Convention Hall)
20-21 North Dakota Hospital Association, Minot
20-21 South Dakota Hospital Association, Yankton
20-23 British Columbia Hospital Association, Vancouver (Vancouver Hotel)
20-23 California Hospital Association, Yosemite (Ahwahnee Hotel)
21-22 Washington State Hospital Association, Yakima (Chinook Hotel)
26-28 Maryland-District of Columbia-Delaware Hospital Association, Washington (Shoreham Hotel)
26-28 Ontario Hospital Association, Toronto (Royal York Hotel)
27-29 Associated Hospitals of Alberta, Edmonton (Jubilee Auditorium)
28-30 Missouri Hospital Association, St. Louis (Sheraton-Jefferson)
29-31 West Virginia Hospital Association, White Sulphur Springs (Greenbrier Hotel)
30 Hospital Council of Greater New York, New York

NOVEMBER

2-4 ***Association of American Medical Colleges,*** Chicago (Edgewater Beach Hotel)
2-6 **Hospital Engineering,** Chicago (AHA Headquarters)
4-7 ***American Association of Blood Banks,*** Chicago (Edgewater Beach Hotel)
5-6 Oklahoma Hospital Association, Tulsa (Mayo Hotel)
9-11 **Basic Institute for Directors of Hospital Volunteers,** Chicago (AHA Headquarters)
9-13 **Physical Therapists,** Houston (Rice Hotel)

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- Housekeeping
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BELOIT, WISCONSIN

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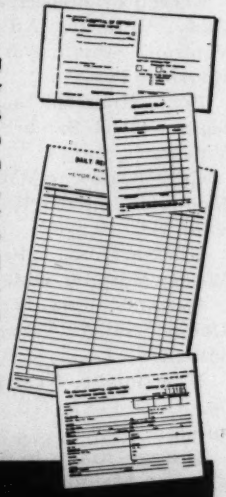

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12-13 Kansas Hospital Association, Kansas City (Town House Hotel)
12-14 Virginia Hospital Association, Old Point Comfort (Hotel Chamberlin)
15-20 ***Radiological Society of North America,*** Chicago (Palmer House)
16-19 **Central Service Administration,** Chicago (AHA Headquarters)
Nov. 29-Dec. 2 ***National Society for Crippled Children and Adults,*** Chicago
Nov. 30-Dec. 4 **Dietary Department Administration,** Portland, Ore. (Multnomah Hotel)

DECEMBER

1-3 **Administrator's Secretaries,** Chicago (AHA Headquarters)
3-4 Hospital Association of Hawaii, Honolulu (Hawaiian Village)
4 Illinois Hospital Association, Springfield (Abraham Lincoln)
7-11 **Hospital Design and Construction,** Chicago (AHA Headquarters)
26-31 ***American Association for the Advancement of Science,*** Chicago

Service from headquarters

(Continued from page 29)

the administrator's employment will continue.

The Hospital Counseling Program has recommended to these hospitals that a contract between administrator and the hospital is a good thing. While such a contract can be violated rather easily by either party, it nevertheless provides a base line for both. This contract should not have a termination date on it but might provide, as part of the agreement, that salary and privileges will be annually reviewed. The major purpose of the contract is to spell out responsibilities of the administrator. These, of course, are broad statements and no attempt should be made to detail them.

Many times, administrators wish to discuss their salaries with the executive committee of the governing board but are unable to find the proper mechanism. However, with a clause in the contract stipulating an annual review, a natural mechanism exists for this discussion.—RICHARD L. JOHNSON

Automatic data processing in hospitals

(Continued from page 51)

maternity; 3) public agencies; 4) Workmen's Compensation; 5) commercial insurance; and 6) other. The next two digits stand for these types of accommodation: 10) private; 11) semiprivate; 12) private ward; 14) nursery; 16) private referred; 17) clinic; 18) emergency; 19) employee; and 20) doctor's laboratory. Numbers 10 through 14 refer to inpatients; 16 through 20 refer to outpatients.

Under this system, an inpatient with Blue Cross regular coverage in a semiprivate room would be coded 111. This three digit code number becomes a permanent entry on the patient's ledger card, along with his admission number, etc. It is keyed into the posting machine after the admission number, remains for all entries, and is cleared automatically when the new balance is cleared.

Each transaction is dated by indexing the date once each day. It is automatically incorporated into each transaction at the time the tape data is transferred to cards by the service bureau. The posting machine is also programed to handle units of service along with dollar amounts. The number of units for a transaction is recorded on the paper tape, but is not printed on the ledger or statement.

6. *Statistical procedure.* Depart-

for bacteriostatic dust control

Ordinary untreated dustcloths pick up many harmful organisms and permit them to multiply at a tremendous rate. Even though they appear clean, these cloths contaminate every surface they touch.

When treated with SANITIZING DUSTCHEK, these same cloths become bacteriostatic. This is demonstrated by the Agar Cup Test against the FDA S. Aureus, the antibiotic resistant S. Aureus 42 B/52/81, the corynebacterium diphtherae and other organisms.

SANITIZING DUSTCHEK permits *controlled impregnation* in bulk with ordinary hospital laundry equipment. It is a concentrated water soluble emulsion, easy and economical to use. For further information, ask your Franklin Research salesman or write direct to the company.

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mental statistics, or units of service, are accumulated from charge tickets and patient ledger cards, and they are classified in the same way as departmental dollar income. These units are compiled according to Section 10 of the *Handbook on Accounting and Statistics for Hospitals* of the American Hospital Association, except for the units of the pathology department.

The classification of statistics is obtained by indexing, at the time of posting to patients' accounts, the number of units of service from the various departments. Indexing patient days, number of operations, deliveries, etc., is unnecessary at the time of posting because a card count is sufficient. As a result of classifying statistics at the same time as dollar amounts are classified, considerable time and labor is saved, and all relevant information is quickly available.

GENERAL BENEFITS GAINED

Coding and indexing, rather than slowing posting, have speeded it. The more legible and accurate patient ledgers produced are easier to process in the Blue Cross and insurance sections of the business office. The results obtained, in terms of analyses of income and statistics, are far superior to those obtained by the old hand method. Further, we are able to supply administration with more detailed information, even though the staff has been reduced. And, last but by no means least, our business office has been relieved of the enormous amount of repetitive work required in keeping records by hand. ■

Theoretical hospital administration

(Continued from page 36)

hospital administration are men and women of wisdom and vision who understand what is happening in hospitals and medicine and are not always taken by surprise by today's crises and the effects of problems whose causes are recognizable and can be anticipated. To learn to think and work in terms of all levels of integration and function may look like a modest demand, but it is no facile accomplished. A certain maturity and capacity for comprehension is necessary to grasp the principle, and the growing awareness of experience is necessary to recognize all of its implications is a process requiring a rather gradual growth of experience. ■

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3. *Ibid.*, pp. 2-3.
4. Atchley, D. W., "The Healer and the Scientist," *The Saturday Review*, New York, Jan. 9, 1954, pp. 7-8.
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Six-way cooperation fights 'staph' in Cincinnati

(Continued from page 45)

the money for operating the laboratory, eliminating extensive and possibly complicated bookkeeping operations.

In addition, the council hospitals have organized, or are in the process of organizing, infections committees and are discussing a plan for an area-wide infections committee to include federal, state, county, city agencies, the hospitals and the medical profession.

The hospitals in and around Cincinnati are aware that the operations of a laboratory and the establishment of the infections committees are not things which in themselves will prevent an epidemic of resistant staphylococcus strains. However, they regard the laboratory and committees as tools and the hospitals are prepared to use them and the other tools of prevention and control to the fullest extent. ■

ASSOCIATION SECTION

(Continued from page 54)

Humphreys County Memorial, Belzoni.
City, Cleveland.
South Sunflower County, Indianola.
Shands, New Albany.
Okolona Community, Okolona.
Pontotoc Community, Pontotoc.
Tippah County, Ripley.

NEW YORK

Union Hospital of the Bronx, New York.
Cross County, Yonkers.

NORTH CAROLINA

C. J. Harris Community, Sylva.
Mercy, Wilson.

PENNSYLVANIA

Erie County Tuberculosis, Erie.
Jersey Shore, Jersey Shore.
The Lucien Moss Home, Philadelphia.

SOUTH CAROLINA

Easley Baptist, Easley.
Florence-Darlington Tuberculosis Sanatorium, Florence.
Oconee Memorial, Seneca.

TENNESSEE

Collins Chapel, Memphis.

TEXAS

Decatur Clinic Hospital, Decatur.
Electra, Electra.

VIRGINIA

Federal Reformatory, Petersburg.

WISCONSIN

Wood County, Marshfield.

WYOMING

North Big Horn, Lovell.

VOTED: To accept the following for listing in the Roster of Hospital Architects Approved by the American Hospital Association:

Robert I. Ballinger Jr., Ballinger Co., Philadelphia 7.
Walk C. Jones Jr., Office of Walk C. Jones Jr., 1215 Poplar Ave., Memphis, Tenn.
Vincent C. Kling, 917 Corinthian Ave., Philadelphia 30.
Paul Nelson, Ketchum & Sharp, 227 E. 44th St., New York 17.
Robert W. Royer, Hewitt & Royer, 7449 Broadway, New York 14.
Fred W. Voss, York & Sawyer, 101 Park Ave., New York 17.

prn

PRO RE NATA

JOHN H. HAYES

I often wonder why one of the manufacturers of vitamins for children has not called his product "Heir Conditioners".

★ ★ ★

The packages of lawn grass seed
Should always bear these words,
"This seed, when planted, you will find,
"Is strictly for the birds".

★ ★ ★

If you have not made plans to attend the AHA convention in August in New York City you are not "on the ball".

The big men and women in industry count convention going as a MUST. Your hospital is at least as important to your town as the biggest industry in it.

Get on the ball!

★ ★ ★

Morbid Morty says, "When I look at what some people call working I realize how difficult it must be to know when they are on strike. Maybe that's why they do picketing."

★ ★ ★

Lyin' ain't easy. It ain't the fear of people catching you at it that bothers you; but the fear of not having another lie ready when they do.

★ ★ ★

There are times, in meetings, when there is no choice: It can be voted to lay a matter on the table, vote it down or refer it to a committee.

★ ★ ★

A good surgeon is one who cares best for his patients by knowing the limits of his competence and his fees.

★ ★ ★

I suppose that nobody ever says anything that has not been said before; maybe not in the same words, but with the same meaning. For instance, I thought of this: "Even a stopped clock is right twice a day. Are you?" I felt that I must have heard that somewhere; looked for it in Bartlett's and another quotation volume without finding it; so I sent it in to the editor. If you see it here it will be because he never heard it before.

★ ★ ★

A girl, when she reaches 16 is usually considered as sweet, attractive.

A boy at that age is considered neither of these things. And he wants it that way.

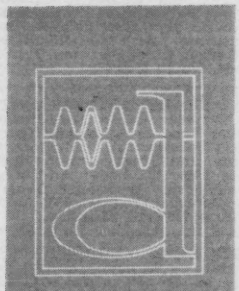
★ ★ ★

When I was a boy I used to daydream of myself as a very brave hero stopping a runaway horse pulling a carriage with a beautiful girl in it.

Just thinking about it now tires me out.

★ ★ ★

If you are earning your living by doing something you do not like to do you are being overworked.



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Positions available HEAD NURSES and STAFF NURSES day, evenings and nights. Differential salary for evenings and nights. Salary commensurate with experience and educational background. Generous personnel policies. School of Nursing affiliated with local community college. Modern round wing opens in fall. Located near New York. Starting salary for Staff Nurses is $315. Starting salary for Head Nurses is $380 for somone with a B.S. Starting rate for others is $345. Address HOSPITALS, Box J-26.

NURSE ANESTHETISTS: for 220 bed community hospital. Working with private group. Two full time M.D.'s, four Nurses, all Agents & Techniques. Modernization program going on. Two and one-half hours from Boston & New York. Write G. J. Carroll, M.D. William W. Backus Hospital, Norwich, Connecticut.

DIETITIAN: ADA member, Therapeutic or Administrative, for 325 bed hospital in western suburb 16 miles west of Chicago's loop. Well equipped Dietary Department. Regular hours. 1 month vacation and other liberal benefits. Salary commensurate with ability. Apply Miss M. L. Schoeneich, Chief Dietitian, Memorial Hospital, Elmhurst, Illinois.

DIRECTOR OF NURSES and SCHOOL OF NURSING: with several years experience and Masters Degree. 465 bed hospital. Excellent personnel policies. Salary open. Write Superintendent, Norfolk General Hospital, Norfolk 7, Virginia.

ASCP registered LABORATORY TECHNICIAN: Florida Hospital; 40-hour week; top salary. Apply to Personnel Director P.O. Box 1990, Daytona Beach, Florida.

A PHYSICAL THERAPIST and an OCCUPATIONAL THERAPIST position is available immediately for a special demonstration project, providing restorative services for patients with chronic disease, in a private nursing home. The physical therapist must be a member or eligible for membership in the A.P.T.A. The occupational therapist must have completed her training and have had at least two years experience. The salaries for both positions start at $439. with a one step increment to $464. in six months. There is a yearly increment with a maximum of $549. The nursing home is located in Belmont, California which is approximately 25 miles from San Francisco. If interested please apply to: George Barnes, Supervisor 111, Special Services Section, San Mateo County Department of Public Health and Welfare, 222 39th Avenue, San Mateo, California.

DIETITIAN: Teaching (A.D.A.); immediate opening, 200-bed general hospital. 40-hour week, liberal personnel policies. Salary commensurate with qualifications. Contact Miss Sutton, Chief Dietitian, Trinity Hospital, Minot, North Dakota.

DEPARTMENT HEAD POSITIONS OPEN: Director of Nursing; Controller; Housekeeper; Medical Records Librarian; Operating, Delivery, Emergency, Central Services Supervisors; and Other positions open. Will open late 1959, 183 beds: Additional 132 beds later. Write: Personnel Department, Baptist Memorial Hospital, 6601 Rockhill Road, Kansas City 10, Missouri.

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INSTRUCTOR: 150 bed hospital with a student body of 70 students. Modern facilities. Located in central Pennsylvania. Must have degree. Good Salary to start. Please send background information and salary wanted, to the Clearfield Hospital, Clearfield, Pennsylvania.

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PHYSICAL THERAPIST FOR EXPANDING DEPARTMENT: Excellent opportunity for a qualified person. Pleasant working conditions and liberal benefits. Salary commensurate with experience. Reply giving training, experience and salary required. Mr. Cercie, R.P.T., Brockton Hospital, 680 Centre Street, Brockton, Mass.

DIETITIAN: Immediate opening for ADA registered hospital trained person to direct dietary program in 115 bed JCHA approved general hospital. Diploma school of nursing of 50 students. Desirable personnel policies and salary. Contact J. E. Janzen, Administrator. Naeve Hospital, Albert Lea, Minnesota.

NURSE ANESTHETIST, ADMINISTRATOR: 26 Bed, Modern Hospital, College Town. Apply: Secretary of the Board, Crete Municipal Hospital, Crete, Nebraska.

NURSE ANESTHETIST for 40-bed community hospital located in a town of 3,000 population. One that is registered or will quality for registration. Good salary and pleasant working conditions. Contact R. O. Maxwell, Adm., Scott County Hospital, Oneida, Tennessee.

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DIETITIAN: A.D.A. preferred, 150 bed hospital, excellent salary with fringe benefits, Wm. Booth Memorial Hospital, Covington, Kentucky.

Tulare-Kings Counties Hospital, Springville, California. A.D.A. DIETITIAN, open now. Salary range $371 to $464. Experienced person may start at second step $392, if better qualified at third step $415. U. S. citizenship, 15 working days vacation after one year; 11 holidays annually. Apply to William A. Winn, M.D., Medical Director, Tulare-Kings Counties Hospital, Springville, California.

NURSE ANESTHETIST: 40 bed hospital, Southern West Virginia, Salary open. Address HOSPITALS, Box J-32.

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POSITIONS WANTED

Experienced hospital credit collection BUSINESS ADMINISTRATOR fair size hospital, middle or western states. Address HOSPITALS Box J-36.

PATHOLOGIST—board certified, early 40's; desires relocation in active, progressive 150-200 bed hospital. Ohio, Pennsylvania or New England. Address HOSPITALS, Box J-34.

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RAndolph 6-5682

ADMINISTRATOR: M.P.H; 8 yrs, personnel director, asst dir, & dir, same lge hsp highly regarded in hsp field; prefers hsp with teaching connections, 250 bds up; Age 38; Member ACHA.

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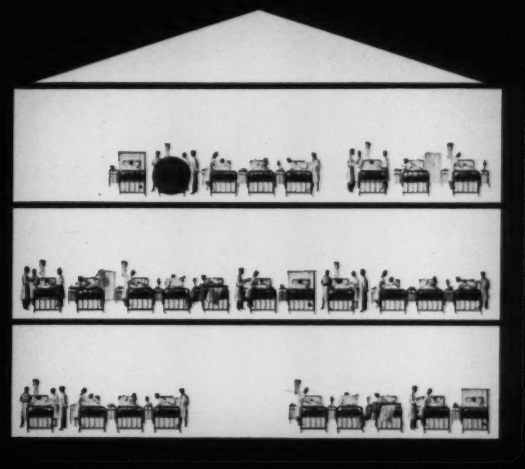
today...
one
case



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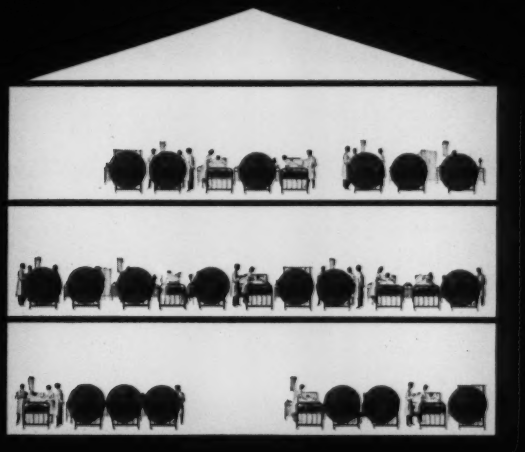

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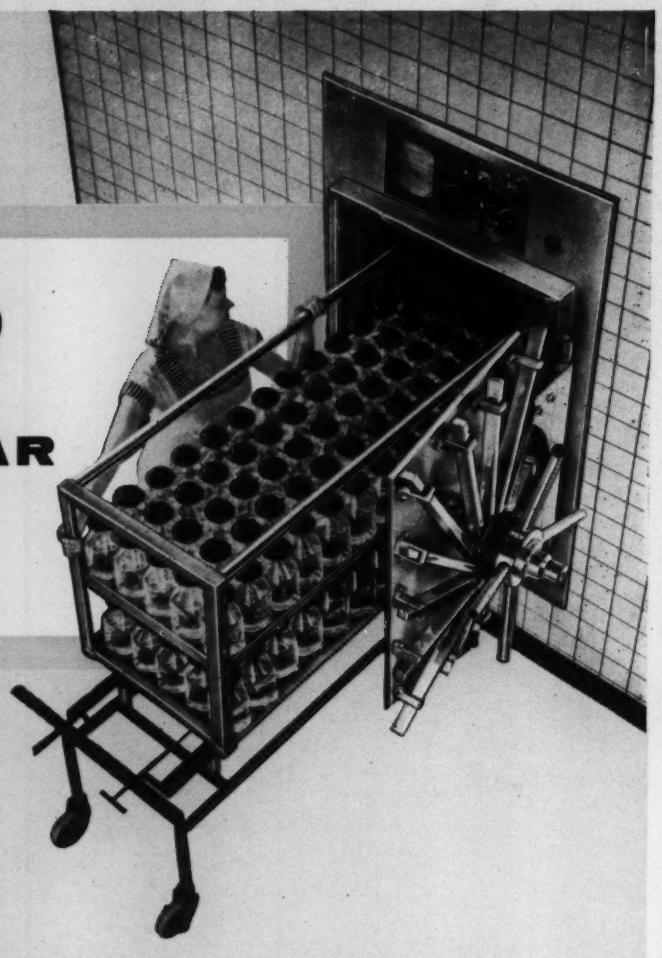

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